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V. David Zvenyach, *General Counsel*

John Hoellen, *Legislative Counsel*

Benjamin F. Bryant, Jr., *Codification Counsel*

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*

PREFACE

These annual cumulative pocket parts update the District of Columbia Official Code, 2001 Edition, with permanent, temporary, and emergency legislation and judicial constructions contained in annotations. These pocket parts contain the Laws, general and permanent in their nature, relating to or in force in the District of Columbia (except such laws as are of application in the General and Permanent Laws of the United States) in effect as of April 1, 2014.

This Supplement also updates the D.C. Code annotations by including notes taken from District of Columbia cases appearing in the following sources: Atlantic Reporter, 3d Series Supreme Court Reporter Federal Reporter, 3d Series Federal Supplement, 2d Series Bankruptcy Reporter.

Current legislation between pamphlets or pocket parts can be accessed online at www.lexisnexis.com/advance, www.lexisnexis.com/research, and http://dcclims1.dccouncil.us/lims.

The unannotated District of Columbia Official Code can be accessed on the District of Columbia Council Website at http://www.dccouncil.us.

Later laws and annotations will be cumulated in subsequent annual Pocket Parts.

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DIVISION VIII. GENERAL LAWS.

TITLE 44. CHARITABLE AND CURATIVE INSTITUTIONS.

SUBTITLE I. HEALTH RELATED INSTITUTIONS.

SUBTITLE II. SPECIAL INSTITUTIONS.

SUBTITLE I. HEALTH RELATED INSTITUTIONS.

Subchapter II. Definitions.

§ 44-102.01. Definitions.

For purposes of this chapter, the term:

(1) "Activities of Daily Living" or "ADLs" means activities including eating, bathing, toileting, grooming, dressing, undressing, mobility, and in place transfers.

(2) "Aging in place" means minimizing the circumstances which require a person to move to a different setting when his or her condition changes.

(3) "Assistant Living Administrator" or "ALA" means the licensee, or a person designated by the licensee, who oversees the day-to-day operation of the facility, including compliance with all regulations for licensed assisted living residences.

(4) "Assisted Living Residence" or "ALR" means an entity, whether public or private, for profit or not for profit, that combines housing, health, and personalized assistance, in accordance to individually developed service plans, for the support of individuals who are unrelated to the owner or operator of the entity. "Assisted Living Residence" or "ALR" does not include a group home for persons with intellectual disabilities as defined in § 44-501(5) or a mental health community residence facility as that term is used in Chapter 38 of Title 22 of the District of Columbia Municipal Regulations.

(5) "Change of ownership" means the transfer of ownership by an individual, partnership, or association to another and includes transfers of the legal or beneficial ownership of 10% or more of the stock of a corporation that owns or operates an ALR.

(6) "Chemical restraint" means the use of a psychopharmacologic drug for a purpose other than to treat a standard psychiatric diagnosis whose criteria are set forth by the American Psychiatric Association.

(7) "Cognitive impairment" means the loss of those mental processes that orchestrate relatively simple ideas, movements, or actions into goal directed behavior including a lack of judgment, planning, organization, self-control, and the persistence needed to manage normal demands of the individual's environment. "Cognitive impairment" refers to a condition that interferes with decision-making skills or effective communication including Alzheimer's disease, multi-infarct dementia, stroke, Parkinson's disease, and other neurological conditions.

(8) "Functional assessment" means an assessment of a resident's ability to perform activities of daily living, instrumental activities of daily living, and the degree of assistance required, if any.

(9) "Health-Care Licensure Act" means subchapter I of Chapter 5 of this title.

(10) "Health-Care Protection Act" means Chapter 10 of this title.

(11) "Healthcare practitioner" means a person licensed as a physician or nurse practitioner.

(12) "Healthcare provider" means a healthcare practitioner, home health agency, hospice, rehabilitation agency, or health management organization.

(13) "In place transfer" means movements that involve changes in position in place. "In place transfer" includes an activity such as moving from a bed to a wheelchair or regular chair, moving from a wheelchair to a toilet, bathtub, shower, or car, and moving from a wheelchair, regular chair, or toilet seat to a standing position.

(14) "Individualized Service Plan" or "ISP" means a written plan developed by the provider, in conjunction with the resident and his or her surrogate, if appropriate, which identifies, among other things, services that the licensee will provide or arrange for the resident.

(15) "Instrumental Activities of Daily Living" or "IADL" means daily activities such as housekeeping, meal preparation, shopping, money management, and travel outside the ALR.

(16) "Licensee" means any person, association, partnership, or corporation to which a license is issued pursuant to this chapter.

(17) "Physical restraint" means any manual method or physical or mechanical device, material, or equipment attached to or adjacent to the resident's body, such as mitts or vests, that the individual cannot remove easily and which restricts freedom of movement or normal access to one's own body.

(18) "Physician's statement" means the form approved by the Mayor pursuant to § 44-108.02(b).

(19) "Resident" means an individual admitted to an ALR pursuant to subchapter VI of this chapter.

(20) "Resident agreement" means the admission agreement between the resident, the resident's surrogate, when appropriate, and the assisted living residence.

(21) "Shared responsibility" means a process by which the resident, or the resident's surrogate, and the ALR arrive at an acceptable balance between the resident's desire for independence and the facility's legitimate concerns for safety, where there is a disagreement. The purpose of "shared responsibility" is to provide complete information to the resident and the surrogate so that the parties can arrive at an informed agreement of which services are to be provided and in what manner.

(22) "Shared responsibility agreement" means a formal written agreement that outlines the responsibilities and actions of all parties. The agreement is a process for resolving discrepancies between the individual resident's right to independence and the provider's concerns for the safety and well being of the individual and others.

(23) "Surrogate" means a person designated by a resident to act on the resident's behalf pursuant to law.

(24) "Trained Medication Employee" or "TME" means an individual employed to work in an ALR who has successfully completed the training program developed by the Mayor pursuant to § 44-109.06 and who is certified to administer medication to residents.

(June 24, 2000, D.C. Law 13-127, § 201, 47 DCR 2647; Apr. 24, 2007, D.C. Law 16-305, § 68(a), 53 DCR 6198; Sept. 26, 2012, D.C. Law 19-169, § 27(a), 59 DCR 5567.)

Section references. — This section is referenced in § 3-1201.02, § 4-205.49, § 44-151.01, § 44-401, and § 44-1001.01.

Effect of amendments.

The 2012 amendment by D.C. Law 19-169 substituted "intellectual disabilities" for "mental retardation" in the second sentence of (4).

Legislative history of Law 19-169. — Law 19-169, the "People First Respectful Language Modernization Amendment Act of 2012," was introduced in Council and assigned Bill No. 19-189. The Bill was adopted on first and second readings on Mar. 6, 2012, and Apr. 17, 2012, respectively. Signed by the Mayor on May 15, 2012, it was assigned Act No. 19-361 and transmitted to Congress for its review. D.C. Law 19-169 became effective on Sept. 26, 2012.

Editor's notes. — Section 35 of D.C. Law 19-169 provided that no provision of the act shall impair any right or obligation existing under law.

Subchapter X. Facility Regulations.

§ 44-110.03. General building exterior.

(a) An ALR shall ensure that the exterior of its facility, including walkways, yards, porches, chimney, gutters, downspouts, paintable surfaces, and accessory buildings are maintained structurally sound, sanitary, and in good repair.

(b) An ALR that provides services to residents who use wheelchairs, shall make reasonable accommodations to render the ALR accessible to residents who use wheelchairs through the installation of a chair lift, curbcuts, an exterior ramp, or like accommodations.

(June 24, 2000, D.C. Law 13-127, § 1003, 47 DCR 2647; Sept. 26, 2012, D.C. Law 19-169, § 27(b), 59 DCR 5567.)

Effect of amendments. — The 2012 amendment by D.C. Law 19-169, in (b), substituted "residents who use wheelchairs" for "wheelchair-bound residents" following "services to" and substituted "residents who use wheelchairs" for "residents who are wheel-chair bound" following "accessible to."

Legislative history of Law 19-169. — Law 19-169, the "People First Respectful Language Modernization Amendment Act of 2012," was introduced in Council and assigned Bill No. 19-189. The Bill was adopted on first and second readings on Mar. 6, 2012, and Apr. 17, 2012, respectively. Signed by the Mayor on May 15, 2012, it was assigned Act No. 19-361 and transmitted to Congress for its review. D.C. Law 19-169 became effective on Sept. 26, 2012.

Editor's notes. — Section 35 of D.C. Law 19-169 provided that no provision of the act shall impair any right or obligation existing under law.

§ 44-110.05. Accessibility.

An ALR that provides services for residents who use wheelchairs, shall insure that:

(1) Doorways and hallways provide a clear opening of at least 32 inches; and

(2) Thresholds exceeding ½ inch are modified to provide a 1:12 maximum slope.

(June 24, 2000, D.C. Law 13-127, § 1005, 47 DCR 2647; Sept. 26, 2012, D.C. Law 19-169, § 27(c), 59 DCR 5567.)

Effect of amendments. — The 2012 amendment by D.C. Law 19-169 substituted "residents who use wheelchairs" for "wheelchair-bound residents" in the introductory language.

Legislative history of Law 19-169. — Law 19-169, the "People First Respectful Language Modernization Amendment Act of 2012," was introduced in Council and assigned Bill No. 19-189. The Bill was adopted on first and second readings on Mar. 6, 2012, and Apr. 17, 2012, respectively. Signed by the Mayor on May 15, 2012, it was assigned Act No. 19-361 and transmitted to Congress for its review. D.C. Law 19-169 became effective on Sept. 26, 2012.

Editor's notes. — Section 35 of D.C. Law 19-169 provided that no provision of the act shall impair any right or obligation existing under law.

§ 44-110.06. Bathrooms.

(a) An ALR shall ensure that there is one full bathroom, for every 6 residents, including live-in family or staff. Additional full or half baths shall be available to non-live-in staff. No resident shall be required to traverse more than one flight of stairs to access a bathroom and appropriate accommodations shall be made for residents who are unable to climb stairs.

(b) When applicable, bathrooms shall contain adequate space and strategically located grab bars to allow residents who use wheelchairs to utilize toilets, tubs, showers, and wash basins without traversing a stair way.

(c) An ALR shall insure that the temperature of the hot water at all taps to which residents have access is controlled by the use of thermostatically controlled mixing valves or by other means, including control at the source, so that the water temperature does not exceed 110 degrees Fahrenheit.

(June 24, 2000, D.C. Law 13-127, § 1006, 47 DCR 2647; Sept. 26, 2012, D.C. Law 19-169, § 27(d), 59 DCR 5567.)

Effect of amendments. — The 2012 amendment by D.C. Law 19-169 substituted "residents who use wheelchairs" for "wheelchair-bound residents" in (b).

Legislative history of Law 19-169. — Law 19-169, the "People First Respectful Language Modernization Amendment Act of 2012," was introduced in Council and assigned Bill No. 19-189. The Bill was adopted on first and second readings on Mar. 6, 2012, and Apr. 17, 2012, respectively. Signed by the Mayor on May 15, 2012, it was assigned Act No. 19-361 and transmitted to Congress for its review. D.C. Law 19-169 became effective on Sept. 26, 2012.

Editor's notes. — Section 35 of D.C. Law 19-169 provided that no provision of the act shall impair any right or obligation existing under law.

CHAPTER 3. GRIEVANCE PROCEDURES FOR HEALTH BENEFITS PLANS.

Subchapter I. Grievance and Appeals Procedure

Subchapter I. Grievance and Appeals Procedure.

§ 44-301.01. Definitions.

For the purposes of this chapter, the term

(1) "Adverse benefit determination" means a denial, reduction, limitation, termination, failure to make a payment for a benefit, or a delay of a benefit to a member, regarding determinations about:

(A) The medical necessity, appropriateness, or level of care, or health care setting;

(B) Whether a benefit is experimental or investigational;

(C) A decision to rescind coverage;

(D) A member's eligibility to participate in a plan;

(E) Whether a wellness incentive has been properly applied; or

(F) Whether the member was given a reasonable alternative standard for satisfying a wellness plan when required.

(1A) "Appeal" means a written request by a member or a member representative for a review of an adverse benefit determination.

(1B) "Director" means the Director of the Department of Health Care Finance.

(2) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(A) Placing the health or mental health of the individual in serious jeopardy;

(B) Serious impairment to bodily functions or mental or emotional functions;

(C) Serious dysfunction of any bodily organ or part or mental or emotional functions; or

(D) With respect to a pregnant woman, placing the health of the woman or her unborn child in serious jeopardy.

(3) "Grievance" means a written request by a member or a member representative for review of a decision of an insurer to deny, reduce, limit, terminate, or delay a benefit to a member, including regarding:

(A) A determination about the medical necessity, appropriateness, or level of care, health-care setting, or effectiveness of a treatment;

(B) A determination as to whether treatment is experimental;

(C) An insurer's decision to rescind coverage;

(D) The failure to provide or make payment that is based on a determination of a member's eligibility to participate in a plan;

(E) Whether a wellness incentive has been properly applied; and

(F) Whether the member was given a reasonable alternative standard for satisfying a wellness plan when required.

(4) "Grievance decision" means a determination accepting or denying the basis or requested remedy of the grievance.

(5) "Health benefits plan" means a group or individual insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangement provided by an insurer or subcontracting facility of an insurer for the purpose of providing, paying for, or reimbursing expenses for health related services. "Health benefits plan" does not include disability income or accident only insurance.

(6) "Health care services" means items or services provided under the supervision of a physician or other person trained or licensed to render health care necessary for the prevention, care, diagnosis, or treatment of human disease, pain, injury, deformity or other physical or mental condition including the following: pre-admission, outpatient, inpatient, and post-discharge care; home care; physician's care; nursing care; medical care provided by interns or residents in training; other paramedical care; ambulance service and care; bed and board; drugs; supplies; appliances; equipment; laboratory services; any form of diagnostic imaging or therapeutic radiological services; and services mandated under Chapter 31 of Title 31.

(7) "Independent review organization" means an impartial, certified health entity engaged by the Director to review any adverse grievance decision by an insurer, including an insurer's decision to deny, terminate, or limit covered health care services.

(8) "Insurer" means any individual, partnership, corporation, association, fraternal benefit association, hospital and medical services corporation, health maintenance organization, or other business entity that issues, amends, or renews group or individual health insurance policies or contracts, including health maintenance organization membership contracts in the District.

(9) "Member" means an individual who is enrolled in a health benefits plan.

(10) "Member representative" means a:

(A) Person acting on behalf of a member with the member's consent;

(B) Person authorized by law to provide substituted consent for a covered person;

(C) Family member of the covered person;

(D) Covered person's treating health care professional when the covered person is unable to provide consent; or

(E) In the case of a request regarding an emergency or urgent medical condition, a health-care professional with knowledge of the covered person's medical condition.

(10A) "Rescission" means a cancellation or discontinuance of coverage that has a retroactive effect (which is prohibited except in cases of fraud or intentional misrepresentation of material fact).

(11) "Urgent medical condition" means a condition with respect to which the application of time periods for making non-urgent claims decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain his or her maximum possible function, or, in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that could not be adequately managed without the health care services being requested.

(Apr. 27, 1999, D.C. Law 12-274, § 101, 46 DCR 1294; Aug. 16, 2008, D.C. Law 17-219, § 5025, 55 DCR 7598; Mar. 19, 2013, D.C. Law 19-229, § 2, 59 DCR 13592.)

Effect of amendments.

The 2013 amendment by D.C. Law 19-229 redesignated former (1) as (1B); added (1) and (1A); rewrote (2), (3), (10), and (11); and added (10A).

Temporary Amendment of Section.

Section 2(a) of D.C. Law 19-200 added a new paragraph (10A) to read as follows:

"For the purposes of this chapter, the term

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"(10A) 'Month' means the period that runs from a given day in one month through the date preceding the numerically corresponding day in the next month."

Section 4(b) of D.C. Law 19-200 provided that the act shall expire after 225 days of its having taken effect.

Emergency legislation.

For temporary (90 day) amendment of section, see § 2(a) of the Health Benefits Plan Grievance Emergency Amendment Act of 2012 (D.C. Act 19-409, July 24, 2012, 59 DCR 9135).

For temporary addition of (10A), see § 2(a) of (D.C. Act 19-502, October 26, 2012, 59 DCR 12757), applicable as of October 22, 2012.

Legislative history of Law 19-229. — Law 19-229, the "Hire Date Reporting Amendment Act of 2012," was introduced in Council and assigned Bill No. 19-376. The Bill was adopted on first and second readings on Oct. 16, 2012, and Nov. 1, 2012, respectively. Signed by the Mayor on Nov. 15, 2012, it was assigned Act No. 19-546 and transmitted to Congress for its review. D.C. Law 19-229 became effective on Mar. 19, 2013.

§ 44-301.03. Establishment of grievance system.

(a)(1) A member or member representative shall have a right to file an appeal with an insurer for a review of an adverse benefit determination. An insurer's health benefits plan shall include an appeal system that provides for the presentation and resolution of appeals brought by members or member representatives.

(2) Health insurers shall notify members when claims are denied, setting forth the reasons for the denial and procedures for appealing the determination through internal and external review. The notice shall be written in a manner calculated to be understood by the participant, in accordance with

federal rules for group health plans promulgated by the U.S. Department of Labor, federal rules for individual health plans promulgated by the U.S. Department of Health and Human Services, and any rules promulgated by the Director pursuant to this chapter.

(3) All notices regarding adverse benefit determinations shall meet the requirements of the Patient Protection and Affordable Care Act of 2010, approved March 23, 2010 (Pub. L. No. 111-148; 124 Stat. 119), regarding cultural and linguistic appropriateness, and, if the insurer is a subcontractor or grantee of a covered entity, as that term is defined in the Language Access Act of 2003, effective June 19, 2004 (D.C. Law 15-167; D.C. Official Code § 2-1931 et seq.)("Language Access Act"), shall also meet the language access standards under the Language Access Act. At a minimum, insurers shall include information in languages identified by the Director about how to obtain free oral interpretation and translation of notices and vital documents.

(b) An appeal system established pursuant to this section shall, at a minimum, incorporate the following components:

(1) The right of a member to file an appeal regarding any aspect of the insurer's health care services;

(2) The right of a member to file an appeal regarding an insurer's decision to rescind coverage;

(3) A procedure for filing an appeal from an adverse benefit determination;

(4) A standardized method of recording, documenting, and reporting the status of all adverse benefit determinations and appeals, which includes the requirements that a health insurer maintain for 6 years records of all claims, and notices associated with the claims, grievances, appeals, and the review process, and limit access to patient-identifying information in those records in accordance with the Health Insurance Portability and Accountability Act of 1996, approved August 21, 1996 (Pub. L. No. 104-191; 110 Stat. 1936), and any other applicable patient confidentiality rules;

(5) Availability of a member services representative to assist members with grievances and appeals upon request;

(6) The right of a member to designate an outside independent representative to assist the member or member representative in following the grievance procedures upon request;

(7) A specified time for responding to appeals not to exceed the time frames set forth in § 44-301.06(f), from receipt of the grievance by the insurer;

(8) An oral and written procedure describing how grievances and appeals are processed and resolved;

(9) Procedures for insurers to follow concerning the methods to be used to inform the member of the resolution; and

(10) In the case of appeals regarding emergency or urgent medical conditions, procedures that will allow a member or member representative to immediately request an expedited review in accordance with §§ 44-301.06 and 44-301.07.

(c) At the time a member first enrolls with an insurer, the insurer shall provide each member with written notice of the components required in subsection (b)(1) through (3) of this section, as well as:

(1) The telephone numbers and business addresses of the insurer's representatives responsible for grievance resolution;

(2) The telephone number, business address, and description of the Health Care Ombudsman's services;

(3) A statement that describes the member's or member representative's right to contact the Director, or the Director's designee, to seek external review if dissatisfied with the resolution reached through the insurer's grievance system; and

(4) A statement that describes a Medicaid or D.C. Health Care Alliance enrollee's right to appeal to the Office of Administrative Hearings at any time, if applicable.

(d) In the case of a reduction or a termination of services that is contrary to the recommendations of the treating physician, mental health professional, or advance practice registered nurse, an insurer shall provide a member or member representative with 24 hours prior verbal notification, followed by a written decision as soon as practical.

(e) An insurer shall include in the "evidence of coverage" and "member handbook" issued to members a description of the procedures for filing grievances and appeals.

(f) An insurer shall not take retaliatory action of any sort against a member who files a grievance pursuant to this section or an appeal pursuant to §§ 44-301.06 and 44-301.07.

(g) The Director or the Director's designee shall waive exhaustion of the appeal process required by § 44-301.06 as a prerequisite for proceeding to the external appeal process:

(1) In cases of emergency or urgent medical conditions;

(2) If the insurer has not complied with the requirements of the internal review process; or

(3) If further participation in the internal appeal process would require the provision of mental health information that the patient or treating mental health professional considered confidential.

(Apr. 27, 1999, D.C. Law 12-274, § 103, 46 DCR 1294; Mar. 19, 2013, D.C. Law 19-229, § 2(b), 59 DCR 13592.)

Section references. — This section is referenced in § 44-301.07.

Effect of amendments. — The 2013 amendment by D.C. Law 19-229 rewrote (a)-(c); added "mental health professional" in (d); substituted "§§ 44-301.06 and 44-301.07" for "§ 44-301.05" in (f); and rewrote (g).

Legislative history of Law 19-229. — See note to § 44-301.01.

§ 44-301.04. Grievance process.

(a) A member or member representative may appeal any adverse benefit determination decision resulting in a rescission, denial, termination, or other limitation of a benefit in accordance with the provisions of this chapter.

(b) At the time an insurer denies, reduces, terminates, or limits a benefit, an insurer shall provide to the affected member or member representative a written description of the procedures for filing appeals, including procedures to

request expedited internal or external review if the matter concerns an emergency or urgent medical condition. The notice shall adhere to requirements of Title XXVII of the Public Health Service Act, approved July 1, 1944 (42 U.S.C. § 300gg et seq.), and the Employee Retirement Income Security Act of 1974, approved September 2, 1974 (Pub. L. No. 93-406; 88 Stat. 829), and shall include information sufficient to identify the claim, the reason for the denial, any standards relied on to deny the claim, contact information for the Health Care Ombudsman, and notice of the right of the claimant to receive free of charge all documents relevant to the claim.

(c) The appeal process shall consist of 2 separate appeal levels:

(1) Review by the insurer; and

(2) External review by an independent review organization.

(d) Nothing in the health benefits plan shall prohibit a member or member representative from discussing or exercising the right to appeal pursuant to this section.

(e)(1) The insurer shall notify a member seeking a resolution of an adverse benefit determination about the:

(A) Availability of the Health Care Ombudsman;

(B) Right to review; and

(C) Procedures for obtaining continued coverage pending the outcome of the grievance.

(2) For grievances and appeals concerning urgent or emergency medical conditions, the member has the right to continued coverage at the level of benefits provided before the reduction, termination, or limitation, pending the outcome of the appeal.

(f)(1) Any request that a physician, with knowledge of the covered person's medical condition, determines involves an emergency or urgent medical condition shall be treated as an urgent care request.

(2) An individual acting on behalf of the health insurer shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine to determine if other requests involve an emergency or urgent medical condition.

(3) For the purposes of expedited external review, the Director, or the Director's designee, shall apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine to determine if other requests involve an emergency or urgent medical condition.

(Apr. 27, 1999, D.C. Law 12-274, § 104, 46 DCR 1294; Mar. 19, 2013, D.C. Law 19-229, § 2(c), 59 DCR 13592.)

Effect of amendments. — The 2013 amendment by D.C. Law 19-229 rewrote (a) through (c); and added (e) and (f).

Legislative history of Law 19-229. — See note to § 44-301.01.

§ 44-301.05. Informal internal review. [Repealed].

Repealed.

(Apr. 27, 1999, D.C. Law 12-274, § 105, 46 DCR 1294; Mar. 19, 2013, D.C. Law 19-229, § 2(d), 59 DCR 13592.)

Legislative history of Law 19-229. — See note to § 44-301.01.

§ 44-301.06. Internal appeals process.

(a)(1) An insurer shall establish and maintain an internal appeals process whereby a member or member representative who has received an adverse benefit determination can have the opportunity to pursue an appeal before a reviewer or panel of physicians, a mental health professional, advanced practice registered nurses, or other health care professionals selected by the insurer.

(2) Group health plans and individual health insurers shall follow claims procedures established pursuant to the Employee Retirement Income Security Act of 1974, approved September 2, 1974 (Pub. L. No. 93-406; 88 Stat. 829), Title XXVII of the Public Health Service Act, approved July 1, 1944 (42 U.S.C. § 300gg et seq.), and the Patient Protection and Affordable Care Act, approved March 23, 2010 (124 Stat. 119; 42 U.S.C. § 18001, note), as amended by the Health Care and Education Reconciliation Act of 2010, approved March 30, 2010 (124 Stat. 1029; 42 U.S.C. § 1305, note), if applicable. At a minimum, the member or member's representative shall be allowed to request an internal review within 180 days of receipt of a notice of an adverse benefit determination.

(b) Reviews shall be in accordance with the following:

(1) The reviewer or panel selected by the insurer pursuant to subsection (a) of this section shall not have been involved in the adverse benefit determination decision under review.

(2) For all reviews requiring medical expertise or mental health expertise, the review panel shall include at least one medical reviewer who is trained or certified in the same specialty as the matter at issue.

(3) A medical reviewer shall be a physician, a mental health professional, an advanced practice registered nurse, or other appropriate health care provider possessing a non-restricted license to practice or provide care anywhere in the United States and the District of Columbia and have no history of disciplinary action or sanctions taken or pending against him or her by any governmental or professional regulatory body.

(4) A medical reviewer shall be certified by a recognized specialty board in the areas appropriate to the review.

(5) The health insurer shall ensure the independence and impartiality of the individuals making review decisions. The health insurer shall not make decisions related to such individuals regarding hiring, compensation, termination, promotion, or other similar matters based upon the likelihood that the individual will support the denial of benefits.

(6)(A) For claims involving mental health care, the confidentiality of mental health information shall be preserved pursuant to Chapter 12 of Title 7 [§ 7-1201.01 et seq.]. Pursuant to a valid authorization, the provider may share limited information as described in § 7-1203.03 to determine payment.

(B) The patient may authorize (or for participating providers, the provider and insurer may jointly authorize) review of the patient's record of mental health information by an independent mental health professional. Mental health information disclosed to an independent mental health professional under these procedures shall not be disclosed to the health insurer.

(c) All internal appeals shall be acknowledged by the insurer, in writing, to the member or member representative filing the appeal within 10 business days of receipt.

(d) The member and the member's representative shall have the right to:

(1) Review the member's file;

(2) Request and receive free of charge copies of all documents and records relevant to the claim;

(3) Present evidence and testimony as part of the appeals process;

(4) Review any new or additional evidence considered or generated by the health insurer;

(5) Review any new or additional rationale used by the insurer in connection with the claim; and

(6) Sufficient opportunity to respond.

(e) The member has the right to continued coverage, upon request, at the level of benefits provided before the reduction, termination, or limitation, pending the outcome of the appeal.

(f) An internal appeal shall be conducted as soon as possible after receipt by the insurer of all necessary documentation in accordance with the medical exigencies of the case. If the internal appeal is from a decision regarding urgent or emergency medical conditions, the insurer shall conclude the appeal within 24 hours of the notification of appeal by the member or member representative. The health insurer shall conclude all other appeals conducted pursuant to this section within 30 calendar days for prospective reviews and 60 calendar days for retrospective reviews.

(g) If an insurer denies a member's or member representative's internal appeal, the insurer shall provide the member or member representative with a written explanation of the denial and written notification of his or her right to receive copies of all documents relevant to the claim and to proceed to an external appeal. The notification shall include specific instructions as to how the member or member representative may arrange for an external appeal and any forms required to initiate an external appeal.

(h) At a minimum, the written explanation provided by the insurer of the determination pursuant to subsection (g) of this section shall include:

(1) The reviewer's understanding of the member's or member representative's complaint;

(2) Information sufficient to identify the claim involved, including, if applicable:

(A) The date of service;

(B) The health care provider;

(C) The claim amount; and

(D) A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning;

(3) The reviewer's decision in clear terms;

(4) The title and qualifying credentials of the person or persons participating in the review, including how those credentials apply to the specific form of treatment being reviewed;

(5) The contractual basis, including reference to specific plan provisions, or medical rationale in enough detail for the member or member representative to understand and to respond to the insurer's position;

(6) A reference to the evidence or documentation used as the basis for the decision, including internal rules, guidelines, and protocols; and

(7) All applicable instructions, including the telephone numbers and titles of persons to contact and the time frames in which to appeal the decision to the next stage of appeal.

(i) If the insurer fails to comply with any of the deadlines or procedures for completion of an internal appeal or if that further participation in the internal process would require the provision of mental health information that the patient or treating mental health professional considered confidential, the member or member representative shall be relieved of his or her obligation to complete the internal review process and may, at his or her option, proceed directly to the external appeals process required by § 44-301.07.

(Apr. 27, 1999, D.C. Law 12-274, § 106, 46 DCR 1294; Mar. 19, 2013, D.C. Law 19-229, § 2(e), 59 DCR 13592.)

Section references. — This section is referenced in § 44-301.03 and § 44-301.07.

Effect of amendments. — The 2013 amendment by D.C. Law 19-229 rewrote the section.

Legislative history of Law 19-229. — See note to § 44-301.01.

§ 44-301.06a. Appeals of rescissions to the Department of Insurance, Securities, and Banking.

If an insurer denies a member or member representative's appeal of a rescission, the insurer shall provide the member or member representative and the Department of Insurance, Securities, and Banking with a written explanation of why the insurer found that there was fraud or misrepresentation of a material fact. The notice shall explain the member's right to appeal to the Department of Insurance, Securities, and Banking.

(Apr. 27, 1999, D.C. Law 12-274, § 106a, as added Mar. 19, 2013, D.C. Law 19-229, § 2(f), 59 DCR 13592.)

Effect of amendments. — The 2013 amendment by D.C. Law 19-229 added this section.

Legislative history of Law 19-229. — See note to § 44-301.01.

§ 44-301.07. External appeals process for matters other than rescissions.

(a) The Director shall establish and maintain an external appeals process whereby a member or member representative who is dissatisfied with a

decision rendered in an internal appeals process shall have the opportunity to pursue an external appeal before an independent review organization. The member or member's representative has a right to pursue an external appeal if:

(1) Dissatisfied with a decision rendered in the internal appeals process;

(2) The health benefit plan or the Director, or Director's designee, waives the requirement that the internal appeals process shall be completed before pursuing an external appeal;

(3) The health plan does not comply with the deadlines and requirements of the internal appeals process; or

(4) The matter concerns an emergency or urgent medical condition and the member or the member representative has applied for expedited external review at the same time as applying for an expedited internal review.

(b) To initiate an external appeal, a member or member representative shall, within 4 months from receipt of the written decision of the formal internal appeal panel, file a written request with the Director. The member or member representative shall submit a signed form allowing the insurer to release medical records of the member that are pertinent to the appeal.

(c) Upon receipt of the request for an external appeal, together with the executed release form, the Director shall determine whether:

(1) The individual was or is a member of the health benefits plan;

(2) The health care service or benefit which is the subject of the appeal reasonably appears to be a benefit or service covered by the health benefits plan, or is not explicitly listed as an excluded benefit and would be a covered benefit except for the insurer's determination that the service or treatment is experimental or investigational for a particular medical condition;

(3) The member or member representative has fully complied with § 44-301.06 regarding internal appeals, or exhaustion of the internal appeals process has been waived in accordance with § 44-301.03(g) or § 44-301.06(i); and

(4) The member or member representative has provided all the information required by the independent review organization and the Director to make the preliminary determination, including the appeal form, a copy of any information provided by the insurer regarding its decision to deny, reduce, or terminate a covered service or benefit, and the release form required pursuant to subsection (b) of this section.

(d) Upon completion of the preliminary review, the Director shall notify the member or member representative and insurer in writing as to whether the appeal has been accepted for processing. If the appeal is accepted by the Director, the Director shall assign the appeal to an independent review organization for full review. If the appeal is not accepted by the Director, the Director shall provide a statement of the reasons for the nonacceptance to the member or member representative and the insurer.

(e) The staff of the independent review organization that is assigned to the appeal pursuant to subsection (d) of this section, shall have meaningful prior experience in performing utilization review, peer review, quality of care assessment or assurance, or the hearing of appeals. Any independent review

organization, its staff, and its professional and medical reviewers, shall not have any material, professional, familial, or financial affiliation with the insurer that is a party to the appeal.

(f) The member or member's representative may initiate an external appeal without exhaustion of the internal appeals process described in § 44-301.06 in a case of an emergency or urgent medical condition, when the insurer has failed to comply with the procedures set forth in § 44-301.06, or when further participation in the internal process would require the provision of mental health information that the patient or treating mental health professional considers confidential.

(g) The insurer shall provide timely access to all its records relating to the matter under review and to all provisions of the health benefits plan or health insurance coverage, including any evidence of coverage, "member handbook", certificate of insurance or contract and health benefits plan relating to the matter.

(h)(1) Upon acceptance of the appeal for processing, the independent review organization shall conduct a full review to determine whether, as a result of the insurer's decision, the member was deprived of any service covered by the health benefits plan. The independent review organization shall notify the member, or member representative, that:

(A) The member may receive from the insurer, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's request for benefits; and

(B) The member may submit additional information in writing to be considered in conducting the review.

(2) The member and member's representative shall be provided at least 10 business days to submit the information pursuant to paragraph (1)(B) of this subsection. To the extent permitted by law, the independent review organization shall forward any information it receives from the member or member's representative to the health insurer within one business day; except, in a case involving mental health information, disclosure of mental health information shall be limited in accordance with § 7-1202.07. Pursuant to § 7-1202.07(b) the member's record of mental health information disclosed for the purpose of independent review shall not be disclosed to the insurer.

(i) The full review of an appeal of a health benefits decision shall be initially conducted by 2 physicians licensed to practice medicine in the District of Columbia, Maryland, or Virginia, or in the case of mental health services, 2 health professional peers with an equal or greater degree of training and experience in the particular kind of mental health treatment under review licensed to practice medicine in the District of Columbia, Maryland, or Virginia. On an exceptions basis, when necessary based on the medical, surgical, or mental condition under review, the independent review organization may select medical reviewers licensed anywhere in the United States who have no history of disciplinary action taken or sanctions pending against them by any governmental or professional regulatory body.

(j)(1) In reaching a determination, the independent review organization shall take into consideration all pertinent medical records, the attending

health care professional's opinion, consulting physician or mental health professional reports, and other documents submitted by the parties, without regard to whether the information was submitted or considered in making the initial adverse decision, any applicable generally accepted practice guidelines developed by the federal government, national, or professional medical societies, boards and associations, and any applicable clinical protocols or practice guidelines developed by the insurer, and may consult with such other professionals as appropriate and necessary.

(2) In a case where a denial was based on the insurer's determination that services or treatments are experimental or investigational, the review organization shall additionally consider medical or scientific evidence or evidence-based standards as to whether the expected benefits of recommended or requested health care service or treatment is more likely to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

(j-1) Before issuing a decision in accordance with the time frames provided in subsection (m) of this section, the independent review organization shall provide free of charge to the member, or member's representative, any new or additional evidence and any new or additional rationale, relied upon or generated by the independent review organization, or at the direction of the health insurer, in connection with the grievance or appeal decision sufficiently in advance of the date the decision is required to be provided to permit the member, or the member's representative, a reasonable opportunity to respond before that date.

(k) The member or member representative and one insurer representative may request to appear in person before the independent review organization. The independent review organization shall conduct the hearing in the District of Columbia. The independent review organization's procedures for conducting a review, when the member or member representative or the insurer has requested to appear in person, shall include the following:

(1) The independent review organization shall schedule and hold a hearing as soon as possible after receiving a request from a member or member representative or from an insurer representative to appear before the independent review organization. The independent review organization shall notify the member or member representative and insurer representative, either orally or in writing, of the hearing date and location. The independent review organization shall not unreasonably deny a request for postponement of the hearing made by the member or member representative or insurer representative.

(2) A member or member representative and an insurer representative shall have the right to the following:

(A) To attend the independent review organization hearing;

(B) To present his or her case to the independent review organization;

(C) To submit supporting material both before and during the hearing;

(D) To ask questions of any representative of the independent review organization;

(E) To be assisted or represented by a person of his or her choice; and

(F) To know the names and qualifications of the reviewers, including their training and experience in the specific form of treatment that is being reviewed, and that they are free from conflicts of interest.

(l)(1) The independent review organization shall consult with a physician, mental health professional, advance practice registered nurse, or other health professional who is an expert in the treatment of the medical or mental health condition that is the subject of the appeal. The expert shall:

(A) Be knowledgeable about the recommended treatment or service through recent or current actual experience treating patients with the same or similar medical or mental health condition as the covered person;

(B) Be licensed and hold the appropriate accreditation or certification for the specialty area under review; and

(C) Have no history of disciplinary actions that raise a substantial question about the reviewer's competence or moral character.

(2) All final recommendations of the independent review organizations shall be approved by the medical director of the independent review organization.

(m) The independent review organization shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case. Except as provided for in this subsection, the independent review organization shall complete its review within 45 calendar days, or 72 hours in the case of an expedited appeal, from the time the Director assigns the appeal to the independent review organization. An insurer shall provide all documentation to the independent review organization within 5 days of receipt of the notice of approval of the appeal by the Director, or within 24 hours of receipt of the notice of approval of the grievance, for an expedited review. If an insurer does not provide the independent review organization all documentation required by this subsection within the time frames, or obtain the necessary extensions, the independent review organization may decide the appeal without receiving the information. The independent review organization shall extend its review for a reasonable period of time as may be necessary due to circumstances beyond its or the insurer's control, but only when the delay will not result in increased medical risk, including increased mental health risk, to the member. In such an event, the independent review organization shall, prior to the conclusion of the initial review period, provide written notice to the member or member representative and to the insurer setting forth the status of its review and the specific reasons for the delay.

(m-1) Expedited appeals shall be furnished:

(1) For appeals concerning admission, availability of care, continued stay, or health care service for which the member received emergency services but has not been discharged from a facility;

(2) When the member is seeking care for an emergency or urgent medical condition; or

(3) When the insurer's denial of coverage is based on its determination that treatment is experimental or investigational; which expedited review shall be conducted upon the treating physician's certification that treatment will be significantly less effective if not promptly initiated.

(n) If the independent review organization determines that the member was deprived of medically necessary covered services or benefits, the independent review organization shall recommend to the Director the appropriate covered health services or benefits the member should receive. The Director shall forward copies of the recommendation to the member or member representative and the insurer.

(o) The independent review organization shall refer a case for review to a consultant physician or other health care provider in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the independent review organization shall be approved by the medical director of the independent review organization.

(p) The decision of the independent review organization shall be binding on the plan or issuer and the member, except to the extent that there are other remedies under District or federal law.

(q)(1) This section shall not apply in cases directly involving Medicaid or the District of Columbia Health Care Alliance benefits.

(2) Any appeal brought pursuant to this section by a member involving coverage provided pursuant to the Medicaid program or the District of Columbia Health Care Alliance program shall be resolved in accordance with federal and District of Columbia laws, regulations, and procedures established for fair hearings and appeals for those programs.

(Apr. 27, 1999, D.C. Law 12-274, § 107, 46 DCR 1294; Mar. 19, 2013, D.C. Law 19-229, § 2(g), 59 DCR 13592.)

Section references. — This section is referenced in § 44-301.03, § 44-301.06, and § 44-301.11.

Effect of amendments. — The 2013 amendment by D.C. Law 19-229 rewrote the section.

Temporary Amendment of Section.

Section 2(b) of D.C. Law 19-200 amended subsections (b) and (p) to read as follows:

"(b) To initiate an external appeal, a member or member representative shall, within 4 months from receipt of the written decision of the formal internal appeal panel, file a written request with the Director. The member or member representative shall submit a signed form allowing the insurer to release medical records of the member that are pertinent to the appeal.

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"(p) The decision of the independent review organization shall be binding on all parties and enforceable by the Director, except to the extent that there are other remedies under District of Columbia or federal law."

Section 4(b) of D.C. Law 19-200 provided that the act shall expire after 225 days of its having taken effect.

Emergency legislation. — For temporary amendment of (b) and (p), see § 2(b) of (D.C. Act 19-502, October 26, 2012, 59 DCR 12757), applicable as of October 22, 2012.

For temporary (90 day) amendment of section, see § 2(b) of Health Benefits Plan Grievance Emergency Amendment Act of 2011 (D.C. Act 19-166, October 11, 2011, 58 DCR 8898).

For temporary (90 day) amendment of section, see § 2(b) of the Health Benefits Plan Grievance Emergency Amendment Act of 2012 (D.C. Act 19-409, July 24, 2012, 59 DCR 9135).

Legislative history of Law 19-229. — See note to § 44-301.01.

§ 44-301.08. Certification and general requirements for independent review organizations.

(a) Each independent review organization selected by the Director to review external appeals must be certified every 2 years by the Director.

(b) The Director shall be responsible for developing, applying, and enforcing

certification standards for independent review organizations. These standards shall ensure that an independent review organization:

(1) Properly maintains a policy involving the review of the appeal in strict confidence pursuant to rules established by the Director and performs reviews at a level of confidentiality equal to or stricter than the standards of confidentiality that are required of the treating health professionals for the treatment being reviewed;

(2) Uses only qualified professional and medical reviewers in any review who do not have conflicts of interest with the patient, the treating health care professional, or the health insurer;

(3) Demonstrates an ability to render decisions in an equitable and timely manner and consistent with this chapter; and

(4) Is accredited by a nationally recognized private accrediting organization.

(c) An independent review organization may not be a subsidiary of, or in any way owned or controlled by a health benefits plan, insurer, or trade association of health care providers.

(d) The Director shall develop an application form for certifying an independent review organization that contains a description of the organization, including names, biographical sketches of all directors, officers, and executives of the organization.

(e) The independent review organization shall submit to the Director the following information, for purposes of creating a file of public records, upon initial application for certification, and thereafter upon any change to any of this information:

(1) The names of all stockholders and owners of more than 5% of any stock or options, if it is a publicly held organization;

(2) The names of all holders of bonds or notes in excess of $100,000 if any;

(3) The names of all corporations and organizations that the independent review organization controls or is affiliated with and the nature and extent of any ownership or control, including the affiliated organization's type of business; and

(4) The names of all directors, officers, and executives of the independent organization, as well as a statement regarding any relationships the directors, officers, and executives may have with any health care plan, disability insurer, managed care organization, health or mental health professional group or board or committee.

(f)(1) The independent review organization shall not have any material professional, familial, or financial conflict of interest with any of the following:

(A) The insurer;

(B) Any officer, director, or management employee of the insurer;

(C) The physician, the physician's medical group, or the independent practice association or the treating provider proposing the service or treatment;

(D) The facility or institution at which the service or treatment would be provided;

(E) The development or manufacture of the principal drug, device,

procedure, or other therapy proposed for the member whose treatment is under review;

(F) The claimant and any related parties to the claimant whose treatment is the subject of the external review; and

(G) The plan administration, plan fiduciaries, or plan employees.

(2) Repealed.

(g) The independent review organization shall have a quality assurance mechanism in place that ensures the timeliness and quality of the reviews, the qualifications and independence of the experts, and the confidentiality of medical records and review materials.

(h) Neither an independent review organization nor an individual working for an external review panel pursuant to this chapter shall be held liable for any recommendation presented by the independent review organization, except in cases of gross negligence, recklessness, or intentional misconduct.

(i) An insurer, bound by the decision of the independent review entity, shall not be liable for following such decision. A determination by the independent review entity in favor of the insurer shall create a rebuttal presumption in any subsequent action at law that the insurer's coverage determination was appropriate.

(j) The Director shall, from time to time, enter into contracts with as many independent review organizations as the Director deems necessary to conduct the external appeals. The contracts shall set forth all terms which the Director deems necessary to ensure a member's right of appeal, including an assessment of separate costs to the insurer for the independent review organization review.

(k) As part of the contract process set forth in subsection (j) of this section, all independent review organizations shall submit to the Director and shall maintain a current list identifying all insurers, health care facilities, and other health care providers with whom the independent review organization maintains any health related business arrangements. The list shall include a brief description of the nature of any such arrangement.

(l) Upon receipt of any request for an external appeal, the Director shall assign that appeal to one of the approved independent review organizations on a random basis. The Director may reserve the right to deny any assignment to any independent review organization if the Director determines that making an assignment would result in a conflict of interest or would otherwise create an appearance of impropriety.

(m) The terms and conditions of a contract entered into pursuant to subsection (j) of this section shall provide that the reasonable direct costs of the external review process, not including costs of representation of a member, shall be paid by the insurer.

(n)(1) An independent review organization assigned pursuant to this chapter to conduct an external review shall maintain written records on all requests for which it conducted an external review during a calendar year.

(2) Each independent review organization shall submit to the Director, upon request, a report on all requests for external reviews.

(3) The report shall include, at minimum:

(A) The total number of requests for external review;

(B) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

(C) The average length of time for resolution;

(D) A summary of the types of coverages or cases for which an external review was sought, provided in the format required by the Director; and

(E) The number of external reviews that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative.

(4) The independent review organization shall retain the written records required pursuant to this subsection for at least 3 years.

(Apr. 27, 1999, D.C. Law 12-274, § 108, 46 DCR 1294; Mar. 19, 2013, D.C. Law 19-229, § 2(h), 59 DCR 13592.)

Effect of amendments. — The 2013 amendment by D.C. Law 19-229 rewrote (b); substituted "health or mental health professional"; for "provider" in (e)(4); substituted "facility or institution" for "institution" in (f)(1); added (f)(1)(F) and (f)(1)(G); repealed (f)(2); added (n); and made related changes.

Legislative history of Law 19-229. — See note to § 44-301.01.

§ 44-301.11. Availability of District external review procedures for self-insured plans.

A group health plan that is located in the District but that is not subject to District regulation may voluntarily use the District's external review system; provided, that it pays the full costs of external review and adheres to the procedures set forth in § 44-301.07.

(Apr. 27, 1999, D.C. Law 12-274, § 111, as added Mar. 19, 2013, D.C. Law 19-229, § 2(i), 59 DCR 13592.)

Effect of amendments. — The 2013 amendment by D.C. Law 19-229 added this section.

Legislative history of Law 19-229. — See note to § 44-301.01.

CHAPTER 4. HEALTH SERVICES PLANNING.

Sec.
44-407. Activities exempt from certificate of need review.

§ 44-407. Activities exempt from certificate of need review.

(a) HCFs and persons proposing projects exempted from certificate of need

review must file with the SHPDA a letter of notice in accordance with rules promulgated pursuant to § 44-421.

(b) The following projects are exempt from certificate of need review:

(1) The upgrading, maintenance, or correction of facility deficiencies that may be in violation of federal and District of Columbia fire, building, and safety codes, or that will improve patient safety related to a pending violation of federal or District of Columbia fire, building, or safety codes;

(2) The correction of deficiencies identified by private national accrediting associations and District government licensing agencies;

(3) Nonpatient care projects requiring the obligation of a capital expenditure of less than $8 million;

(4) The acquisition of the same or similar medical equipment to replace, upgrade, or expand the capacity of the equipment for which a certificate of need has been granted, if the replaced equipment is removed from service;

(5) The acquisition of major medical equipment to be used solely for research, new institutional health services to be offered solely for research, or the obligation of a capital expenditure to be made solely for research. This provision shall not preclude a HCF from seeking reasonable reimbursement for health care services provided under this exemption;

(6) Repealed.

(7) Any proposal to offer or develop a new institutional health service or obligate a capital expenditure which would otherwise be subject to this section, if the purpose of the service or expenditure is to accommodate a resident to be transferred from D.C. Village;

(8) The voluntary permanent reduction in the number in licensed bed capacity where a request for exemption is made 60 days before the reduction and the SHPDA finds that the reduction in bed capacity would not be inconsistent with the HSP;

(9) For a period of one year, commencing on December 18, 2001, any increase in the licensed psychiatric bed capacity by a private general hospital, psychiatric hospital, other specialty hospital or rehabilitation facility holding a certificate of need to operate psychiatric beds. The health care facility shall provide the Department of Mental Health with a copy of the letter of notice required by SHPDA for projects exempt from certificate of need review;

(10) The acquisition of major medical equipment or establishment of new institutional health services determined by the Department to be necessary for a declared public health purpose or deemed necessary by the Department to provide health care services under contract to or grant from a District of Columbia or federal agency. Participation in programs under Titles XVIII and XIX of the Social Security Act does not qualify as a District of Columbia or federal contract for purposes of this exemption;

(11) District of Columbia public, chartered, and private schools for any health care service offered or developed for students with special needs in compliance with the Individuals with Disabilities Education Act, approved June 4, 1997 (111 Stat. 37; 20 U.S.C. § 1400 et seq.), the Rehabilitation Act of 1973, approved August 7, 1998 (112 Stat. 1092; 29 U.S.C. § 701 et seq.), or the Early and Periodic Screening, Diagnosis, and Treatment Program under Title

XIX of the Social Security Act, approved July 30, 1965 (79 Stat. 343; 42 U.S.C. § 1396 et seq.), or any other federal or District of Columbia legal requirements; and

(12) The acquisition, prior to October 1, 2003, of any single piece of diagnostic or therapeutic equipment which was acquired by lease, purchase, donation, or other comparable arrangement by or on behalf of a physician, a group of physicians, a private group practice of diagnostic radiology or radiation therapy, or a diagnostic health care facility, or the replacement of such equipment, so long as the equipment to be replaced is removed from service; and

(13) Upon October 20, 2005, any increase in the licensed psychiatric bed capacity by a private general hospital, psychiatric hospital, or other specialty or rehabilitation hospital holding a certificate of need to operate psychiatric beds; provided, that the Department of Mental Health has requested such expansion specific to a reduction in psychiatric acute care services offered by Saint Elizabeths Hospital.

(b-1) For the purposes of a project exempt under subsection (b)(13) of this section, the facility shall provide the Department of Mental Health with a copy of the letter of notice required by SHPDA for projects exempt from the certificate of need review.

(b-2) Changes in ownership, whether voluntary or involuntary, of the short-term, acute-care hospital known as the United Medical Center and a long-term acute-care hospital and a skilled-nursing facility at the same location, known as the Southern Avenue Facilities, shall be exempt from the certificate-of-need requirements for the purpose of:

(A) Allowing the transfer from the owner of record to another owner of all or a portion of the Southern Avenue Facilities;

(B) Notwithstanding any other provision of District law, allowing the owner of record, a subsequent owner, or caretaker, regardless of whether the transfer is voluntary or involuntary, to close or terminate a health service outside of the United Medical Center within 30 days after July 7, 2010; or

(C) Allowing the entity acquiring the United Medical Center to establish, within 90 days of July 7, 2010, a skilled-nursing facility with no more than 120 beds in the existing buildings located in the 1300 block of Southern Avenue, S.E.

(c) An HMO, or combination of HMOs, shall be exempt from certificate of need requirements if it meets the following requirements:

(1) The facility in which the service will be provided is or will be geographically located so that the service will be reasonably accessible to the enrolled individuals; and

(2) At least 75% of the patients who can reasonably be expected to receive the health service will be individuals enrolled in the HMO or combination of HMOs.

(d) The District government is exempt from certificate of need requirements until January 1, 1998.

(e) Any proposal to offer or develop a new institutional health service, obligate a new capital expenditure, or reduce or terminate a health service that

would otherwise be subject to certificate of need requirements, by a health care entity that has contracted with the District of Columbia Financial Responsibility Management Assistance Authority, or with the Mayor pursuant to § 7-1405, to provide new health care services shall be exempt from certificate of need requirements only for the purpose of maintaining the same level of care and services provided by the District of Columbia Health and Hospitals Public Benefit Corporation ("Public Benefit Corporation"). The exemptions granted by this subsection shall be for a period of 225 days from July 12, 2001, except that proposals to develop trauma I capability to match the levels existing at D.C. General Hospital as of January 1, 2001, shall be exempt from certificate of need requirements for a period of 1 year from July 12, 2001.

(f) The Administrator of the Health Care Safety Net Administration ("Administrator"), established pursuant to § 7-1401, shall determine which new institutional health services, capital expenditures, and reductions or terminations of health services qualify as health care services being taken over from the Public Benefit Corporation. The Administrator's authority to make determinations and the exemptions from certificate of need review pursuant to subsection (e) shall expire 1 year after the date the first contract for health care services entered into pursuant to § 7-1405 is signed.

(g) The District government and the Public Benefit Corporation are exempt from certificate of need requirements for any changes in health care service that may result from the abolishment of the Public Benefit Corporation.

(April 9, 1997, D.C. Law 11-191, § 8, 43 DCR 4535; July 12, 2001, D.C. Law 14-18, § 8(3), 48 DCR 4047; Dec. 18, 2001, D.C. Law 14-56, § 116(i)(3), 48 DCR 7674; Apr. 22, 2004, D.C. Law 15-149, § 2(e), 51 DCR 2802; Oct. 20, 2005, D.C. Law 16-33, § 5123, 52 DCR 7503; Sept. 14, 2011, D.C. Law 19-21, § 5150, 58 DCR 6226; Sept. 26, 2012, D.C. Law 19-171, §§ 108, 109, 59 DCR 6190.)

Section references. — This section is referenced in § 44-406.

Effect of amendments.

The 2012 amendment by D.C. Law 19-171 redesignated the last sentence in (b)(13) as (b-1); redesignated (b)(14) as (b-2) and made related changes; and added "For the purposes of a project exempt under subsection (b)(13) of this section" in (b-1).

Legislative history of Law 19-171. — Law 19-171, the "Technical Amendments Act of 2012," was introduced in Council and assigned Bill No. 19-397. The Bill was adopted on first and second readings on Mar. 20, 2012, and Apr. 17, 2012, respectively. Signed by the Mayor on May 23, 2012, it was assigned Act No. 19-376 and transmitted to Congress for its review. D.C. Law 19-171 became effective on September 26, 2012.

CHAPTER 5. HEALTH-CARE AND COMMUNITY RESIDENCE FACILITY, HOSPICE AND HOME CARE LICENSURE.

Subchapter I. Licensure

Subchapter II. Unlicensed Personnel Criminal Background Check

Subchapter I. Licensure.

§ 44-501. Definitions.

(a) For the purposes of this subchapter the term:

(1) "Hospital" means a facility that provides 24-hour inpatient care, including diagnostic, therapeutic, and other health-related services, for a variety of physical or mental conditions, and may in addition provide outpatient services, particularly emergency care.

(2) "Maternity center" means a facility or other place, other than a hospital or the mother's home, that provides antepartal, intrapartal, and postpartal care for both mother and child during and after normal, uncomplicated pregnancy.

(3) "Nursing home" means a 24-hour inpatient facility, or distinct part thereof, primarily engaged in providing professional nursing services, health-related services, and other supportive services needed by the patient/resident.

(4) "Community residence facility" means a facility that provides a sheltered living environment for individuals who desire or need such an environment because of their physical, mental, familial, social, or other circumstances, and who are not in the custody of the Department of Corrections. All residents of a community residence facility shall be 18 years of age or older, except that, in the case of group homes for persons with intellectual disabilities, no minimum age shall apply, unless this requirement is waived in accordance with § 44-505(e).

(5) "Group home for persons with intellectual disabilities" means a community residence facility that provides a home-like environment for at least 4 but no more than 8 related or unrelated individuals who on account of intellectual disabilities require specialized living arrangements, and maintains the necessary staff, programs, support services, and equipment for their care and habilitation.

(6) "Hospice" means an agency, organization, facility, or distinct part thereof, primarily engaged in providing a program of in-home, outpatient, or inpatient medical, nursing, counseling, bereavement, and other palliative and supportive services to terminally ill individuals and their families.

(7) "Home care agency" means an agency, organization, or distinct part thereof, other than a hospice, that directly provides skilled nursing services and at least one other therapeutic service to an individual, in his or her home or in a community residence facility, who is sick or who has a disability.

(8) "Ambulatory surgical facility" means any facility, other than a hospital or maternity center but including an office-based facility, at which there are performed outpatient surgical and related procedures that have been classified in accordance with § 44-504(h) due to their complexity or the degree of patient risk.

(9) "Renal dialysis facility" means any place, other than a hospital or the patient's home, that provides therapeutic care for persons with acute or chronic renal failure through the use of hemodialysis, peritoneal dialysis, or any other therapy that clears the blood of substances normally excreted by the kidneys.

(10) "Therapeutic service" includes physical, speech, or occupational therapy; medical social services; or personal care services.

(b) The Mayor shall have the authority to define variant types of facilities and agencies reasonably classified within the broader categories defined in subsection (a) of this section, and may issue rules under § 44-504 with respect to these subtypes. The Mayor shall make the final determination of whether a particular facility or agency falls within a category defined in subsection (a) of this section or a subtype defined by the Mayor pursuant to this subsection.

(c) When used throughout this act, the terms "facility" and "agency" and their plural forms shall, unless contextually inappropriate or subject to specific exception, apply to all of the facilities and agencies defined in subsection (a) of this section as well as those subtypes defined by the Mayor. The Mayor shall make the final determination of whether a provision is contextually inappropriate for a particular agency or facility.

(Feb. 24, 1984, D.C. Law 5-48, § 2, 30 DCR 5778; Mar. 14, 1985, D.C. Law 5-154, § 2(a), 32 DCR 7; Sept. 5, 1985, D.C. Law 6-26, § 2(a), 32 DCR 3615; Feb. 28, 1987, D.C. Law 6-215, § 2(a), 34 DCR 893; July 8, 1988, D.C. Law 7-131, § 3, 35 DCR 4106; Mar. 16, 1989, D.C. Law 7-199, § 3, 36 DCR 3; Mar. 24, 2007, D.C. Law 16-305, § 69, 53 DCR 6198; Sept. 26, 2012, D.C. Law 19-169, § 28, 59 DCR 5567; March 26, 2014, D.C. Law 20-96, § 202, 61 DCR 1184.)

Section references. — This section is referenced in § 2-220.05, § 3-405, § 3-1205.01, § 4-204.61, § 4-205.49, § 7-701.01, § 7-703.02, § 7-832, § 7-1531.01, § 7-2341.01, § 8-2031, § 21-2202, § 21-2209, § 44-102.01, § 44-151.01, § 44-631, § 44-651, § 44-801, § 44-1001.01, § 44-1051.02, § 47-1261, and § 50-1641.05.

Effect of amendments.

The 2012 amendment by D.C. Law 19-169 substituted "intellectual disabilities" for "mental retardation" wherever it appears in (a)(4) and (a)(5).

The 2014 amendment by D.C. Law 20-96 rewrote (a)(7); and added (a)(10).

Legislative history of Law 19-169. — Law 19-169, the "People First Respectful Language Modernization Amendment Act of 2012," was introduced in Council and assigned Bill No. 19-189. The Bill was adopted on first and second readings on Mar. 6, 2012, and Apr. 17, 2012, respectively. Signed by the Mayor on May 15, 2012, it was assigned Act No. 19-361 and transmitted to Congress for its review. D.C. Law 19-169 became effective on Sept. 26, 2012.

Legislative history of Law 20-96. — Law 20-96, the "Omnibus Health Regulation Amendment Act of 2014," was introduced in Council and assigned Bill No. 20-153. The Bill was adopted on first and second readings on December 3, 2013 and January 7, 2014, respectively. Signed by the Mayor on February 5, 2014, it was assigned Act No. 20-273 and transmitted to Congress for its review. D.C. Law 20-96 became effective on March 26, 2014.

Editor's notes.

Section 35 of D.C. Law 19-169 provided that no provision of the act shall impair any right or obligation existing under law.

§ 44-504. Rules.

(a) The Mayor shall issue rules, consistent with other provisions of this chapter and pursuant to subchapter I of Chapter 5 of Title 2, establishing:

(1) License fees for private facilities and agencies reasonably calculated to reflect a facility's or agency's respective share of the cost of administering the provisions of this subchapter and rules adopted pursuant to this subchapter;

(2) Procedures deemed necessary to effectuate the purposes of this subchapter, including, but not limited to, procedures for:

(A) Issuing and renewing licenses;

(B) Obtaining variances;

(C) Ensuring that 6 months after the adoption of applicable rules under this subsection, licensure of all affected facilities and agencies shall be under the new rules;

(D) Waiving the inspection requirements of § 44-505(a) and (b) for those agencies that deliver services within the District of Columbia but are headquartered and licensed outside the District of Columbia, when, in the opinion of the Mayor, licensure by another jurisdiction constitutes sufficient evidence that the agency is in substantial compliance with District of Columbia law;

(E) Processing and following up on complaints by facility and agency staff, consumers, and advocates that are filed with the governmental licensing authority;

(F) Suspending or revoking the license of a facility or agency that is in violation of any provision of this subchapter, rule adopted pursuant to this subchapter, or other provision of District of Columbia or federal law, or whose governing body, chief executive officer, administrator, or director has made a material misrepresentation of fact to a government official with respect to the facility's or agency's compliance with any provision of this subchapter, rule adopted pursuant to this chapter, or other provision of District of Columbia or federal law; and

(G) Appealing from adverse licensure decisions;

(3) Standards for the construction and operation of each type of facility and agency, including standards governing: safety and sanitation of facilities; organizational governance and administration; employee and volunteer training, staff membership and delineation of clinical privileges (in addition to the standards set forth in § 44-507), and other personnel matters; diagnostic, therapeutic, emergency, anesthesia, laboratory, pharmaceutical, dietary, nursing, rehabilitation, social, emergency and non-emergency transportation, and other services; infection control; patient/client/resident care and quality assurance; recordkeeping; utilization review; and internal complaint and appeal procedures; and

(4) A statement of patients', clients', and residents' rights and responsibilities for each type of facility and agency, including the right to nondiscrimination in treatment or access to services based on reasons prohibited by Unit A of Chapter 14 of Title 2.

(b) Repealed.

(c) In formulating the standards and statements of rights and responsibilities required by subsection (a)(3) and (4) of this section, the Mayor shall, within 30 days after February 24, 1984, appoint an advisory task force for each type of facility and agency except ambulatory surgical facilities and renal dialysis facilities. Each task force shall be composed of consumers, providers, advocates, and government agency representatives, and shall be charged with the responsibility of making formal written recommendations within a time frame established by the Mayor. The Mayor shall give substantial consideration to each task force's recommendations and shall, on a continuing basis before adoption of proposed rules, maintain a dialogue with each task force while reviewing and acting on its recommendations.

(d) Where appropriate, standards adopted under subsection (a)(3) of this section may incorporate, in whole or in part, the standards of private accrediting bodies and standard-setting organizations, as well as the federal conditions of participation and standards for health-insurance and medical-assistance programs. Whenever the standards of a private accrediting body or standard-setting organization are revised and a copy is submitted to the Mayor, the Mayor shall evaluate the revised standards and determine whether any or all of them should be incorporated into new rules.

(e) Community residence facilities shall distribute a copy of the statement required by subsection (a)(4) of this section to each resident's parents, guardian, or other responsible person acting on his or her behalf. All other facilities shall conspicuously post copies of this statement near the main entrance and on every floor. Agencies shall distribute a copy of this statement to each patient/client upon the initial delivery of services. Each copy shall specifically state, in boldface, the address and telephone number of the appropriate in-house or intra-agency personnel and governmental authority to which complaints should be addressed.

(e-1) For nursing facility residents, the statement required by subsection (a)(4) of this section shall include, at a minimum, the right to:

(1) Be fully informed by the nursing facility of all resident rights and all facility rules governing resident conduct and responsibilities upon admission and annually thereafter;

(2) Either manage one's own personal finances, or be given a quarterly report of the resident's finances if this responsibility has been delegated in writing to the nursing facility;

(3) Be treated with respect and dignity and assured privacy during treatment and when receiving personal care;

(4) Not be required to perform services for the nursing facility that are not for therapeutic purposes, as identified in the plan of care for the resident;

(5) Associate and communicate privately with persons of the resident's choice, unless medically contraindicated;

(6) Send and receive personal mail, unopened by personnel at the nursing facility;

(7) Participate in activities of social, religious, and community groups at the discretion of the resident, unless medically contraindicated;

(8) Keep and use personal clothing and possessions, as space permits, unless to do so would infringe on other residents' rights or is medically contraindicated;

(9) Maintain, at the nursing facility, a private locker, chest, or chest drawer that is large enough to accommodate jewelry and small personal property and that can be locked by the resident;

(10) Be provided with privacy for visits by the resident's spouse or domestic partner, or, if spouses or domestic partners are both residents in the nursing facility, be permitted to share a room;

(11) Be free from mental or physical abuse;

(12) Be free from chemical and physical restraints except as authorized pursuant to federal or District law and regulation;

(13) Be transferred or discharged only for the grounds set forth in § 44-1003.01; and

(14) Be discharged from the nursing facility after:

(A) Receiving a consultation from a physician of the medical consequences of discharge; and

(B) Providing the administrator, physician, or a nurse of the nursing facility written notice of the desire to be discharged; provided, that if the resident is a minor or a guardian has been appointed for a resident, the written request for discharge shall be signed by the resident's guardian, unless there is a court order to the contrary.

(f) In setting standards under subsection (a)(3) of this section, the Mayor shall require that hospice and home care agency programs be centrally administered and organized to ensure effective coordination of all patient/client care services.

(g) Nothing in this section shall be construed to prohibit a facility or agency from supplementing the standards adopted under subsection (a)(3) of this section by establishing internal standards, policies, and procedures that promote safety and quality care, so long as they are reasonable and not inconsistent with this subchapter, rules adopted pursuant to this subchapter, or other District of Columbia law.

(h) For ambulatory surgical facilities, the rules required by subsection (a) of this section shall include a list of those outpatient surgical procedures that, if not performed in a hospital or, when appropriate, a maternity center, may be performed only in a facility licensed as an ambulatory surgical facility. In formulating this list of procedures before its publication as a proposed rule, the Mayor shall solicit input from a broad range of health professionals, relevant institutional providers, and other members of the public who are knowledgeable about ambulatory surgery or ambulatory surgical facilities. This list shall be periodically reviewed and updated by rulemaking pursuant to subchapter I of Chapter 5 of Title 2.

(h-1)(1) As part of the standards for nursing facilities required by subsection (a)(3) of this section, the Mayor shall require nursing facilities to:

(A) Maintain an organizational and staffing structure that promotes assignment of the same caregivers to care for the same residents as often as practicable;

(B) Except as provided in paragraph (2) of this subsection:

(i) Beginning January 1, 2011, have either a physician, physician assistant, or an advanced practice registered nurse, excluding the medical director, available on-site for a minimum of 0.2 hours per week for each resident at the facility; and

(ii) Beginning January 1, 2012, provide a minimum daily average of 4.1 hours of direct nursing care per resident per day, of which at least 0.6 hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by sub-subparagraph (i) of this subparagraph;

(C) Provide annual training to all nursing home employees on the appropriate use of emergency transport and 911 services;

(D) Make each resident's attending physician's contact information readily available to facility staff as well as to each resident and his or her family or legal representative upon request;

(E) Provide employee training that addresses the special health care needs of the elderly and that addresses the needs of specific populations, including those characterized by:

(i) Race;

(ii) Ethnicity;

(iii) Religious affiliation;

(iv) Sexual orientation;

(v) Gender; and

(vi) Gender identity;

(F) Ensure that appropriate health care services are available on-site, as determined by the Department of Health, for the purpose of reducing the need to transport residents off-site for routine health services, including:

(i) Podiatry;

(ii) Rehabilitative services, such as physical therapy and occupational therapy;

(iii) Wound care;

(iv) Mental health;

(v) Dialysis; and

(vi) Substance-abuse treatment;

(G) Develop and maintain written policies and procedures governing the management and operation of the facility, which shall be required by the Department of Health as a component of licensure, reviewed by the Department of Health, and made available upon request, including policies and procedures governing:

(i) Nursing services;

(ii) Physician services;

(iii) Emergency care;

(iv) Dental services;

(v) Ventilator services;

(vi) Use of physical and chemical restraints;

(vii) Infection control;

(viii) Medication management;

(ix) Podiatry services;

(x) Dialysis services;

(xi) Recreational services;

(xii) Emergency water supply;

(xiii) Laundry and linen management;

(xiv) Fire and disaster preparedness; and

(xv) Resident emergency and non-emergency transportation.

(H) Based on a resident's right to participate in resident and family groups (Requirements For Long Term Care Facilities, 42 C.F.R. § 483.15(c)), make available to any resident or family group:

(i) Promotional and advertising assistance so that residents and residents' family members are aware of their right to convene groups;

(ii) Adequate meeting space and logistical assistance;

(iii) Information regarding policies and procedures for nursing home care, resident rights and responsibilities, and laws and rules that apply to the facility and its residents;

(iv) Staff for the operation of each meeting, upon request; and

(v) Written feedback and responses to recommendations and grievances;

(I) Ensure that a resident is seen by a physician within 72 hours of admission and has recorded in his or her medical record:

(i) An evaluation of the resident's primary diagnoses;

(ii) The resident's:

(I) Height;

(II) Weight;

(III) Mental health status; and

(IV) Personal care needs;

(iii) Whether it is medically contraindicated for the resident to participate in:

(I) Physical;

(II) Recreational; or

(III) Rehabilitative activities; and

(iv) An evaluation of any existing:

(I) Medical care plan;

(II) Treatment orders; and

(III) Medications;

(J) Obtain a medical order from the resident's attending physician, the facility's medical director, an on-staff physician, or advanced practice registered nurse if a resident requires medical treatment prior to calling 911; provided, that a prior medical order shall not be required if it is determined that there is a situation that requires an immediate transfer to a hospital; provided further, that if a nursing facility does not obtain a required medical order prior to calling 911, the facility shall document in the resident's medical record why obtaining a medical order was not practicable; and

(K) Conduct a discharge assessment within 14 days of admission, and biannually thereafter, that includes:

(i) A time frame for discharging the resident to return home or to another facility; and

(ii) If the resident is likely to be discharged within 6 months of the discharge assessment, a discharge plan.

(2) The Department of Health shall have the authority to adjust the staffing requirements and formulas set forth in paragraph (1)(B)(i) and (ii) of this subsection based on the individual needs of a nursing facility; provided, that the staffing requirements set forth in paragraph (1)(B)(ii) of this subsection shall never be less than 3.5 hours of direct nursing care per resident per day.

(i)(1) As part of the standards for hospitals and renal dialysis facilities required by subsection (a)(3) of this section, the Mayor shall establish standards and procedures with respect to:

(A) The labeling, handling, transporting, storage, routine inspection, and preventive maintenance of dialysis equipment;

(B) The reprocessing and reuse of hemodialyzers, dialysate port caps, and blood port caps;

(C) Water purification and quality;

(D) The flushing of residues from potentially toxic sterilants and disinfectants used during manufacture or reprocessing;

(E) The facility's responsibility to ensure individualized treatment, including the most appropriate choice of equipment for each patient and, for patients exhibiting hypersensitivity, the use of biocompatible membranes;

(F) The reporting of equipment failures and occurrences of pyrexia, sepsis, or bacteremia;

(G) The training, minimum qualifications, and supervision of dialysis staff; and

(H) The training and support provided to self-dialysis and home dialysis patients.

(2) The standards and procedures required by paragraph (1) of this subsection shall not be less stringent than the guidelines set forth in the July 28, 1986, Recommended Practice for Reuse of Hemodialyzers published by the Association for the Advancement of Medical Instrumentation ("AAMI Recommended Practice") and the recommendations of the Centers for Disease Control referenced in those guidelines ("CDC Recommendations").

(3) Until the standards and procedures required by paragraph (1) of this subsection become enforceable through licensure, hospitals and renal dialysis facilities shall comply with the AAMI Recommended Practice, except that, where there are CDC Recommendations, hospitals and renal dialysis facilities shall comply with the CDC Recommendations.

(4) No hospital or renal dialysis facility shall reuse blood tubing or transducer protectors.

(5) No hospital or renal dialysis facility shall reuse a hemodialyzer or dialyzer caps on a patient unless that patient has first signed a written consent form after having been orally advised by a physician of the potential risks, benefits, and uncertainties surrounding reuse and the disinfection process. The advising physician shall not be a medical director of the facility or dialysis unit, nor shall he or she have a financial interest in the facility. The information conveyed shall consist of a full and fair presentation of representative opinions from those in the medical community who have expressed concerns about reuse practices, and those who support these practices. Any discussion of "first-use syndrome" shall include information about advances in biocompatible-membrane technology.

(6) Dialysis patients shall have the following nonwaivable rights, to be supplemented by the statement of rights and responsibilities established by the Mayor pursuant to subsection (a)(4) of this section:

(A) To revoke or limit, either orally or in writing, a previously executed reuse consent at any time and for any reason;

(B) To be informed before each dialysis treatment of the number of times the dialyzer and dialyzer caps have been previously used;

(C) To have documented in their patient-care records all consents to reuse, refusals to consent, revocations of consent, and limitations placed upon consent;

(D) To have unrestricted access to their patient-care records;

(E) To make the reuse-content decision in an environment devoid of threats, intimidation, or retaliation by the facility or its staff; and

(F) Except as provided by paragraph (7) of this subsection, to remain at a facility and receive treatments with a new, state-of-the-art dialyzer and new dialyzer caps whenever consent to reuse is refused or revoked or reuse is prohibited by limitations placed upon consent.

(7) A hospital or renal dialysis facility may transfer or decline to admit a patient on account of that patient's refusal to consent to the reuse of hemodialyzers or dialyzer caps only if:

(A) The Mayor certifies that the facility is currently in full compliance with this subsection and all other District of Columbia laws that regulate, either directly or indirectly, the reprocessing and reuse of hemodialyzers and dialyzer caps;

(B) The facility, in cooperation with a patient-care ombudsman designated by the Mayor, identifies and secures a permanent placement for the patient in an alternative facility within the District of Columbia where that patient will be provided the option of receiving each treatment with a new, state-of-the-art dialyzer and new dialyzer caps; and

(C) The patient-care ombudsman designated by the Mayor finds that the patient can obtain equally reliable transportation to and from the alternative facility without suffering extreme physical, psychological, or financial hardship.

(8) Paragraphs (3) through (7) of this subsection shall be applicable and enforceable with respect to all hospitals and renal dialysis facilities, whether licensed or temporarily exempt from licensure under § 44-502(c), immediately on February 28, 1987.

(j) The proposed rules, except those rules that establish or modify license fees as described in subsection (a) of this section, shall be submitted to the Council for a 45-day period of review, excluding Saturdays, Sundays, legal holidays, and days of Council recess. If the Council does not approve or disapprove the proposed rules, in whole or in part, by resolution within this 45-day review period, the proposed rules shall be deemed approved. Nothing in this section shall affect any requirements imposed upon the Mayor by subchapter I of Chapter 5 of Title 2.

(k) Any license issued pursuant to this section shall be issued as a Public Health: Health Care Facility endorsement or a Public Health: Human Services Facility endorsement to a basic business license under the basic business license system as set forth in subchapter I-A of Chapter 28 of Title 47.

(Feb. 24, 1984, D.C. Law 5-48, § 5, 30 DCR 5778; Sept. 5, 1985, D.C. Law 6-26, § 2(b)-(d), 32 DCR 3615; Feb. 28, 1987, D.C. Law 6-215, § 2(b), (c), 34 DCR 893; Oct. 1, 1992, D.C. Law 9-168, § 2(a), (b), 39 DCR 5822; Apr. 20, 1999, D.C. Law 12-261, § 2003(aa)(2), 46 DCR 3142; Oct. 28, 2003, D.C. Law 15-38,

§ 3(ee)(2), 50 DCR 6913; Apr. 13, 2005, D.C. Law 15-354, § 83(c)(2), 52 DCR 2638; Oct. 20, 2005, D.C. Law 16-33, § 5002, 52 DCR 7503; Apr. 29, 2010, D.C. Law 18-145, § 3(a), 57 DCR 1834; Sept. 26, 2012, D.C. Law 19-171, § 110, 59 DCR 6190.)

Section references. — This section is referenced in § 44-501, § 44-502, § 44-505, § 44-506, § 44-509, § 44-1002.02, § 44-1004.01, and § 44-1004.03.

Effect of amendments.

The 2012 amendment by D.C. Law 19-171 validated a previously made technical correction in (a)(3).

Legislative history of Law 19-171. — Law 19-171, the "Technical Amendments Act of 2012," was introduced in Council and assigned Bill No. 19-397. The Bill was adopted on first and second readings on Mar. 20, 2012, and Apr. 17, 2012, respectively. Signed by the Mayor on May 23, 2012, it was assigned Act No. 19-376 and transmitted to Congress for its review. D.C. Law 19-171 became effective on September 26, 2012.

§ 44-506. Provisional and restricted licenses.

(a) As an alternative to denial, nonrenewal, suspension, or revocation of a license when a facility or agency has numerous deficiencies or a serious single deficiency with respect to the standards to be established under § 44-504(a)(3), the Mayor may:

(1) Issue a provisional license if the facility or agency is taking appropriate ameliorative action in accordance with a mutually agreed upon timetable; or

(2) Issue a restricted license that prohibits the facility or agency from accepting new patients/clients/residents or delivering certain specified services that it would otherwise be authorized to deliver, if appropriate ameliorative action is not forthcoming.

(b) As provided in § 44-505(a), provisional licenses may be issued to new facilities and agencies in order to afford the Mayor sufficient time and evidence to evaluate whether a new facility or agency is capable of complying with the provisions of this subchapter, rules adopted pursuant to this subchapter, and other applicable provisions of law.

(c) Provisional licenses may be granted for a period not exceeding 90 days, and may be renewed no more than once.

(d) Any provisional license issued pursuant to this section shall be issued as a provisional Public Health: Health Care Facility endorsement or a provisional Public Health: Human Services facility endorsement to a basic business license under the basic business license system as set forth in subchapter I-A of Chapter 28 of Title 47.

(e) If a facility is issued a restricted or provisional license, the Department of Health may, if appropriate, appoint a temporary manager or monitor in accordance with a mutually agreed upon timetable or until the facility becomes compliant with § 44-504(a)(3) and (h-1).

(Feb. 24, 1984, D.C. Law 5-48, § 7, 30 DCR 5778; Apr. 20, 1999, D.C. Law 12-261, § 2003(aa)(3), 46 DCR 3142; Oct. 28, 2003, D.C. Law 15-38, § 3(ee)(3), 50 DCR 6913; Apr. 29, 2010, D.C. Law 18-145, § 3(c), 57 DCR 1834; Sept. 26, 2012, D.C. Law 19-171, § 112, 59 DCR 6190.)

Section references. — This section is referenced in § 44-505.

Effect of amendments.

The 2012 amendment by D.C. Law 19-171 validated a previously made technical correction.

Legislative history of Law 19-171. — Law 19-171, the "Technical Amendments Act of 2012," was introduced in Council and assigned Bill No. 19-397. The Bill was adopted on first and second readings on Mar. 20, 2012, and Apr. 17, 2012, respectively. Signed by the Mayor on May 23, 2012, it was assigned Act No. 19-376 and transmitted to Congress for its review. D.C. Law 19-171 became effective on September 26, 2012.

Editor's notes.

Section 112 of D.C. Law 19-171 amended subsection (e) of this section by striking the phrase "with § 44-504(a)(3)" and inserting the phrase "with section 8(a)(3) [of D.C. Law 5-48]" in its place. The legislative intent was to substitute in the phrase "with section 5(a)(3)," codified as § 44-504(a)(3), rather than the phrase "with section 8(a)(3)," and has been implemented accordingly.

Subchapter II. Unlicensed Personnel Criminal Background Check.

§ 44-551. Definitions.

For purposes of this subchapter, the term:

(1A) "Contract worker" means a compensated contractor for whom it is foreseeable he or she will come in direct contact with patients.

(1B) "Criminal background check" means an investigation into a person's criminal history to determine whether, within the 7 years preceding the background check, the person has been convicted in the District of Columbia, or in any other state or territory of the United States where such person has worked or resided, of any of the offenses enumerated in § 44-552(e) or their equivalent in another state or territory.

(1C) "Facility" means any entity required to be licensed pursuant to subchapter I of this chapter or Chapter 1 of this title and any entity furnishing Medicaid services under a provider agreement with the District of Columbia in accordance with regulations promulgated under title XIX of the Social Security Act, approved July 30, 1965 (Pub. L. 89-97; 42 U.S.C. § 1396 et seq.).

(2) Repealed.

(3) "Medicaid services" means nursing facility services, home health-care services, inpatient hospital services and nursing facilities for individuals 65 years of age or older in an institution for mental disease, mental health rehabilitation services in an intermediate care facility for persons with intellectual disabilities home and community care for elderly individuals with functional disabilities, and community supported living arrangement services as defined in title XIX of the Social Security Act, approved July 30, 1965 (Pub. L. 89-97; 42 U.S.C. § 1396 et seq.).

(4) "Nurse Aide Abuse Registry" means a record, maintained by the District of Columbia in accordance with section 4211 of the Omnibus Budget Reconciliation Act of 1987, approved December 22, 1987 (101 Stat. 1330-182; 42 U.S.C. § 1396r), and 29 DCMR § 3250-3254, containing names of individuals who worked as nurse aides and were determined to have abused or neglected, or misappropriated the property of, a nursing home resident.

(5) "Person" means an individual.

(6) "Private agency" means an entity or person that offers customer assistance in the use of criminal background checks for employment purposes.

(7) "Unlicensed person" means a person not licensed pursuant to Chapter 12 of Title 3, who functions in a complementary or assistance role to licensed health care professionals in providing direct patient care or in performing common nursing tasks. The term "unlicensed person" includes nurse aides, orderlies, assistant technicians, attendants, home health aides, personal care aides, medication aides, geriatric aides, or other health aides. The term "unlicensed person" also includes housekeeping, maintenance, and administrative staff for whom it is foreseeable that the prospective employee or contract worker will come in direct contact with patients.

(Apr. 20, 1999, D.C. Law 12-238, § 2, 46 DCR 881; Apr. 12, 2000, D.C. Law 13-91, § 148(a), 47 DCR 520; June 24, 2000, D.C. Law 13-127, § 1403, 47 DCR 2647; Dec. 18, 2001, D.C. Law 14-56, § 116(k), 48 DCR 7674; Apr. 13, 2002, D.C. Law 14-98, § 2(a), 49 DCR 997; Apr. 24, 2007, D.C. Law 16-305,§ 70, 53 DCR 6198; Mar. 25, 2009, D.C. Law 17-353, §§ 200, 201, 56 DCR 1117; Sept. 26, 2012, D.C. Law 19-169, § 29, 59 DCR 5567.)

Effect of amendments.

The 2012 amendment by D.C. Law 19-169 substituted "intellectual disabilities" for "mental retardation" in (3).

Legislative history of Law 19-169. — Law 19-169, the "People First Respectful Language Modernization Amendment Act of 2012," was introduced in Council and assigned Bill No. 19-189. The Bill was adopted on first and second readings on Mar. 6, 2012, and Apr. 17, 2012, respectively. Signed by the Mayor on May 15, 2012, it was assigned Act No. 19-361 and transmitted to Congress for its review. D.C. Law 19-169 became effective on Sept. 26, 2012.

Editor's notes. — Section 35 of D.C. Law 19-169 provided that no provision of the act shall impair any right or obligation existing under law.

CHAPTER 6A. HOSPITAL ASSESSMENTS.

Sec.
44-633. Assessments on hospitals.

§ 44-633. Assessments on hospitals.

(a) Each hospital in the District of Columbia shall pay to the Mayor an annual assessment as follows:

(1) For fiscal year 2010, $500 per licensed bed, which shall be paid by September 1, 2010, and which shall be deposited in the Medical Liability Captive Trust Fund, established by § 1-307.91, to be used for the purposes of this fund; and

(2) For fiscal year 2011, $2,529 per licensed bed and for fiscal years 2012 through 2014, $3,788 per licensed bed, which shall be paid based on a schedule determined by the Mayor and which shall be deposited in the Hospital Fund, established by § 44-632, to be used for the purpose of this fund.

(b) The Chief Financial Officer may determine the manner in which payments are to be made under this chapter, including whether payments owed by each hospital pursuant to subsection (a) of this section shall be paid electronically.

(Sept. 24, 2010, D.C. Law 18-223, § 5014, 57 DCR 6242; Apr. 8, 2011, D.C. Law

18-370, § 512, 58 DCR 1008; Sept. 14, 2011, D.C. Law 19-21, § 8182, 58 DCR 6226; Sept. 26, 2012, D.C. Law 19-171, § 111, 59 DCR 6190.)

Effect of amendments.

The 2012 amendment by D.C. Law 19-171 made a technical correction to D.C. Law 19-21 which did not affect this section as codified.

Legislative history of Law 19-171. — Law 19-171, the "Technical Amendments Act of 2012," was introduced in Council and assigned Bill No. 19-397. The Bill was adopted on first and second readings on Mar. 20, 2012, and Apr. 17, 2012, respectively. Signed by the Mayor on May 23, 2012, it was assigned Act No. 19-376 and transmitted to Congress for its review. D.C. Law 19-171 became effective on September 26, 2012.

CHAPTER 6B. MEDICAID HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT.

§ 44-651. Definitions.

For the purposes of this chapter, the term:

(1) "Department" means the Department of Health Care Finance.

(2) "Gross patient revenue" means the amount calculated in accordance with generally accepted accounting principles for hospitals that is reported as the sum of Worksheet G-2; Column 1; Lines 1, 2, 2.01, 15, 17 and 18 and Worksheet G-2; Column 2; Lines 17, 18, 18.5 and 18.51 of the Medicare Cost Report (2552-96), excluding long-term care inpatient ancillary revenues.

(3) "Hospital" shall have the same meaning as provided in § 44-501(a)(1), but excludes any hospital operated by the federal government.

(4) "Hospital system" means any group of hospitals licensed separately but operated, owned, or maintained by a common entity.

(5) "Medicaid" means the medical assistance programs authorized by Title XIX of the Social Security Act, approved July 30, 1965 (79 Stat. 343; 42 U.S.C. § 1396 et seq.), and by § 1-307.02, and administered by the Department of Health Care Finance.

(Dec. 24, 2013, D.C. Law 20-61, § 5072, 60 DCR 12472.)

Emergency legislation. — For temporary (90 days) addition of this section, see § 5072 of the Fiscal Year 2014 Budget Support Emergency Act of 2013 (D.C. Act 20-130, July 30, 2013, 60 DCR 11384, 20 DCSTAT 1827).

For temporary (90 days) addition of this section, see § 5072 of the Fiscal Year 2014 Budget Support Congressional Review Emergency Act of 2013 (D.C. Act 20-204, October 17, 2013, 60 DCR 15341, 20 DCSTAT 2311).

Legislative history of Law 20-61. — Law 20-61, the "Fiscal Year 2014 Budget Support Act of 2013," was introduced in Council and assigned Bill No. 20-199. The Bill was adopted on first and second readings on May 22, 2013, and June 26, 2013, respectively. Signed by the Mayor on Aug. 28, 2013, it was assigned Act No. 20-157 and transmitted to Congress for its review. D.C. Law 20-61 became effective on Dec. 24, 2013.

Short title. — Section 5071 of D.C. Law 20-61 provided that Subtitle H of Title V of the act may be cited as the "Medicaid Hospital Outpatient Supplemental Payment Act of 2013".

Editor's notes. — Applicability of D.C. Law

20-61: Section 11001 of D.C. Law 20-61 provided that, except as otherwise provided, the act shall apply as of October 1, 2013.

§ 44-652. Hospital Provider Fee Fund.

(a) Effective May 1, 2013, there is established as a special fund the Hospital Provider Fee Fund ("Fund"), which shall be administered by the Department and used in accordance with subsection (c) of this section.

(b) The Fund shall consist of revenue from the following sources:

(1) All moneys collected or received by the Department from the hospital provider fee imposed by this chapter;

(2) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to moneys deposited in the Fund;

(3) Interest and penalties collected under this chapter; and

(4) Interest earned by the Fund.

(c) Notwithstanding any other provision of law, the Fund may only be used for the following purposes:

(1) For making Medicaid outpatient hospital access payments to hospitals as required under § 44-655;

(2) For payment of administrative expenses incurred by the Department or its agent in performing the activities authorized by this chapter at an amount not to exceed the prorated amount of $150,000 annually; and

(3) For making refunds to hospital providers pursuant to § 44-654.

(d)(1) The money deposited into the Fund, and interest earned, shall not revert to the unrestricted fund balance of the General Fund of the District of Columbia at the end of a fiscal year, or at any other time.

(2) Subject to authorization by Congress, any funds appropriated in the Fund shall be continually available without regard to fiscal year limitation.

(e) The Fund shall not be used to replace any moneys appropriated to the Medicaid program.

(Dec. 24, 2013, D.C. Law 20-61, § 5073, 60 DCR 12472.)

Section references. — This section is referenced in § 44-653.

Emergency legislation. — For temporary (90 days) addition of this section, see § 5073 of the Fiscal Year 2014 Budget Support Emergency Act of 2013 (D.C. Act 20-130, July 30, 2013, 60 DCR 11384, 20 DCSTAT 1827).

For temporary (90 days) addition of this section, see § 5073 of the Fiscal Year 2014 Budget Support Congressional Review Emergency Act of 2013 (D.C. Act 20-204, October 17, 2013, 60 DCR 15341, 20 DCSTAT 2311).

Legislative history of Law 20-61. — See note to § 44-651.

Short title. — Section 5071 of D.C. Law 20-61 provided that Subtitle H of Title V of the act may be cited as the "Medicaid Hospital Outpatient Supplemental Payment Act of 2013".

Editor's notes. — Applicability of D.C. Law 20-61: Section 11001 of D.C. Law 20-61 provided that, except as otherwise provided, the act shall apply as of October 1, 2013.

§ 44-653. Hospital provider fee.

(a) Subject to § 44-654, the District may charge a fee at a uniform rate on the gross patient revenue of each hospital beginning May 1, 2013. The District

may charge the fee retroactively to May 1, 2013, upon the effective date of this chapter. The uniform rate shall be applied to each hospital's gross patient revenue as derived from each hospital's filed Medicare cost report ending between July 1, 2009, and June 30, 2010. The hospital provider fee is applied at a uniform rate necessary to generate the following:

(1) An amount equal to the non-federal share of the total available spending room under the Medicaid upper payment limit for private hospitals applicable to District fiscal years ("DFY") 2013 and 2014 consistent with the federal approval of the authorizing Medicaid State Plan amendment; plus

(2) An amount equal to the lesser of the non-federal share of the total available spending room under the Medicaid upper payment limit for District operated hospitals applicable to DFY 2013 and 2014 consistent with the federal approval of the authorizing Medicaid State Plan amendment or United Medical Center's Medicaid disproportionate share hospital limit as adjusted by the District in accordance with the federally approved Medicaid State Plan; plus

(3) An amount equal to the Department's administrative expenses as described in § 44-652(c)(2).

(b) A psychiatric hospital provider that is an agency or a unit of the District government is exempt from the fee imposed under this chapter, unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case a psychiatric hospital provider that is an agency or a unit of the District government shall pay the fee imposed by this chapter.

(Dec. 24, 2013, D.C. Law 20-61, § 5074, 60 DCR 12472.)

Section references. — This section is referenced in § 44-654, § 44-656, and § 44-657.

Emergency legislation. — For temporary (90 days) addition of this section, see § 5074 of the Fiscal Year 2014 Budget Support Emergency Act of 2013 (D.C. Act 20-130, July 30, 2013, 60 DCR 11384, 20 DCSTAT 1827).

For temporary (90 days) addition of this section, see § 5074 of the Fiscal Year 2014 Budget Support Congressional Review Emergency Act of 2013 (D.C. Act 20-204, October 17, 2013, 60 DCR 15341, 20 DCSTAT 2311).

Legislative history of Law 20-61. — See note to § 44-651.

Short title. — Section 5071 of D.C. Law 20-61 provided that Subtitle H of Title V of the act may be cited as the "Medicaid Hospital Outpatient Supplemental Payment Act of 2013".

Editor's notes. — Applicability of D.C. Law 20-61: Section 11001 of D.C. Law 20-61 provided that, except as otherwise provided, the act shall apply as of October 1, 2013.

§ 44-654. Applicability of fees.

(a) The fee imposed by § 44-653 shall not be due and payable until such time that the federal Centers for Medicare and Medicaid Services approves the Medicaid State Plan amendment authorizing the Medicaid payments described in § 44-655.

(b) The fee imposed by § 44-653 shall cease to be imposed, and any moneys remaining in the Fund shall be refunded to hospital providers in proportion to the amounts paid by them, if:

(1) The Department makes changes in its rules that reduce the hospital inpatient or outpatient Medicaid payment rates, including adjustment payment rates, in effect on October 1, 2012; or

(2) The payments to hospitals required under § 44-655 are modified in

any way other than to secure federal approval of such payments as described in § 44-655 or are not eligible for federal matching funds under Title XIX of the Social Security Act.

(c) The fee imposed by § 44-653 shall not take effect or shall cease to be imposed if the fee is determined to be an impermissible tax under Title XIX of the Social Security Act.

(d) Should the fee imposed by § 44-653 not take effect or cease to be imposed, moneys in the Fund derived from the imposed fee shall be disbursed in accordance with § 44-655 to the extent federal matching is available. If federal matching is not available due to a determination by the Centers for Medicare and Medicaid Services that the provider fee is impermissible, any remaining moneys shall be refunded to hospital providers in proportion to the amounts paid by them.

(Dec. 24, 2013, D.C. Law 20-61, § 5075, 60 DCR 12472.)

Section references. — This section is referenced in § 44-652 and § 44-653.

Emergency legislation. — For temporary (90 days) addition of this section, see § 5075 of the Fiscal Year 2014 Budget Support Emergency Act of 2013 (D.C. Act 20-130, July 30, 2013, 60 DCR 11384, 20 DCSTAT 1827).

For temporary (90 days) addition of this section, see § 5075 of the Fiscal Year 2014 Budget Support Congressional Review Emergency Act of 2013 (D.C. Act 20-204, October 17, 2013, 60 DCR 15341, 20 DCSTAT 2311).

Legislative history of Law 20-61. — See note to § 44-651.

Short title. — Section 5071 of D.C. Law 20-61 provided that Subtitle H of Title V of the act may be cited as the "Medicaid Hospital Outpatient Supplemental Payment Act of 2013".

Editor's notes. — Applicability of D.C. Law 20-61: Section 11001 of D.C. Law 20-61 provided that, except as otherwise provided, the act shall apply as of October 1, 2013.

§ 44-655. Medicaid outpatient hospital access payments.

(a) For visits and services beginning May 1, 2013, quarterly Medicaid outpatient hospital access payments shall be made to each private hospital. Each payment will be equal to the hospital's DFY 2011 outpatient Medicaid payments divided by the total private hospital DFY 2011 outpatient Medicaid payments multiplied by one quarter of the total outpatient private hospital access payment pool minus $250,000. The total outpatient private hospital access payment pool is equal to the total available spending room under the private hospital outpatient Medicaid upper payment limit for DFY 2013 and 2014, respectively.

(b) The remaining $250,000 shall be distributed as an adjustment to the quarterly access payments for all private children's hospitals with less than 150 beds and distributed based on the hospital's DFY 2011 outpatient Medicaid payments relative to the total qualifying hospitals' DFY 2011 outpatient Medicaid payments.

(c) Any private hospital that is also a Disproportionate Share Hospital ("DSH") will receive no more than the available room under their District-adjusted, hospital-specific DSH limit. Any Medicaid outpatient hospital access payments that would otherwise exceed a private disproportionate share hospital's adjusted DSH limit shall be distributed to the remaining private hospitals consistent with each private hospital's relative share of DFY 2011 Medicaid payments.

(d) For visits and services beginning May 1, 2013, outpatient hospital access payments shall be made to the United Medical Center. Each payment will be equal to one quarter of the total outpatient public hospital access payment pool. The total outpatient public hospital access payment pool is equal to the lesser of the total available spending room under the District-operated hospital outpatient Medicaid upper payment limit for DFY 2013 and 2014, respectively, and the United Medical Center District-adjusted Medicaid DSH limit.

(e) The quarterly Medicaid outpatient hospital access payments shall be made within 15 business days of the end of each DFY quarter for the Medicaid visits and services rendered during that quarter.

(f) No payments shall be made under this section until such time that the federal Centers for Medicare and Medicaid Services approves the Medicaid State Plan amendment authorizing the Medicaid payments described in this chapter.

(g) The Medicaid payment methodologies authorized under this chapter shall not be altered in any way unless such alteration is necessary to gain federal approval from the Centers for Medicare and Medicaid Services.

(Dec. 24, 2013, D.C. Law 20-61, § 5076, 60 DCR 12472.)

Section references. — This section is referenced in § 44-652, § 44-654, and § 44-656.

Emergency legislation. — For temporary (90 days) addition of this section, see § 5076 of the Fiscal Year 2014 Budget Support Emergency Act of 2013 (D.C. Act 20-130, July 30, 2013, 60 DCR 11384, 20 DCSTAT 1827).

For temporary (90 days) addition of this section, see § 5076 of the Fiscal Year 2014 Budget Support Congressional Review Emergency Act of 2013 (D.C. Act 20-204, October 17, 2013, 60 DCR 15341, 20 DCSTAT 2311).

Legislative history of Law 20-61. — See note to § 44-651.

Short title. — Section 5071 of D.C. Law 20-61 provided that Subtitle H of Title V of the act may be cited as the "Medicaid Hospital Outpatient Supplemental Payment Act of 2013".

Editor's notes. — Applicability of D.C. Law 20-61: Section 11001 of D.C. Law 20-61 provided that, except as otherwise provided, the act shall apply as of October 1, 2013.

§ 44-656. Quarterly notice and collection.

(a) The fee imposed under § 44-653 shall be due and payable by the 15th of the last month of each DFY quarter.

(b) The fee imposed under § 44-653 shall be calculated, due, and payable on a quarterly basis, but shall not be due and payable until:

(1) The District issues the written notice that the payment methodologies to hospitals required under § 44-655 have been approved by the federal Centers for Medicare and Medicaid Services;

(2) The District issues written notice to each hospital informing the hospital of its fee rate, gross patient revenue subject to the fee, and the fee amount owed on a quarterly basis; and

(3) The initial written notice from the District shall include all fee amounts owed beginning with the period May 1, 2013, to ensure all applicable fee obligations have been identified.

(c) When a hospital fails to pay the full amount of its fee by the date required, the unpaid balance shall accrue interest at the rate of 1.5% per month or any fraction thereof, which shall be added to the unpaid balance. The

Chief Financial Officer may arrange a payment plan for the amount of the fee and interest in arrears.

(d) The payment by the hospital of the fee created in this chapter shall be reported as an allowable cost for purposes of Medicaid hospital reimbursement.

(Dec. 24, 2013, D.C. Law 20-61, § 5077, 60 DCR 12472.)

Emergency legislation. — For temporary (90 days) addition of this section, see § 5077 of the Fiscal Year 2014 Budget Support Emergency Act of 2013 (D.C. Act 20-130, July 30, 2013, 60 DCR 11384, 20 DCSTAT 1827).

For temporary (90 days) addition of this section, see § 5077 of the Fiscal Year 2014 Budget Support Congressional Review Emergency Act of 2013 (D.C. Act 20-204, October 17, 2013, 60 DCR 15341, 20 DCSTAT 2311).

Legislative history of Law 20-61. — See note to § 44-651.

Short title. — Section 5071 of D.C. Law 20-61 provided that Subtitle H of Title V of the act may be cited as the "Medicaid Hospital Outpatient Supplemental Payment Act of 2013".

Editor's notes. — Applicability of D.C. Law 20-61: Section 11001 of D.C. Law 20-61 provided that, except as otherwise provided, the act shall apply as of October 1, 2013.

§ 44-657. Multi-hospital systems, closure, merger, and new hospitals.

(a) If a hospital system conducts, operates, or maintains more than one hospital licensed by the Department of Health, the provider shall pay the fee for each hospital separately.

(b) Notwithstanding any other provision in this chapter, in the case of a person who ceases to conduct, operate, or maintain a hospital for which the person is subject to the fee under this chapter as a hospital provider, the fee for the DFY in which the cessation occurs shall be adjusted by multiplying the fee computed under § 44-653 by a fraction, the numerator of which is the number of days in the year during which the provider conducts, operates, or maintains the hospital and the denominator of which is 365. Immediately upon ceasing to conduct, operate, or maintain a hospital, the person shall pay the fee for the year as so adjusted (to the extent not previously paid).

(c) Notwithstanding any other provision in this chapter, a provider who conducts, operates, or maintains a hospital, upon notice by the Department, shall pay the fee computed under § 44-653 and subsection (a) of this section in installments on the due dates stated in the notice and on the regular installment due dates for the DFY occurring after the due dates of the initial notice.

(Dec. 24, 2013, D.C. Law 20-61, § 5078, 60 DCR 12472.)

Emergency legislation. — For temporary (90 days) addition of this section, see § 5078 of the Fiscal Year 2014 Budget Support Emergency Act of 2013 (D.C. Act 20-130, July 30, 2013, 60 DCR 11384, 20 DCSTAT 1827).

For temporary (90 days) addition of this section, see § 5078 of the Fiscal Year 2014 Budget Support Congressional Review Emergency Act of 2013 (D.C. Act 20-204, October 17, 2013, 60 DCR 15341, 20 DCSTAT 2311).

Legislative history of Law 20-61. — See note to § 44-651.

Short title. — Section 5071 of D.C. Law 20-61 provided that Subtitle H of Title V of the

act may be cited as the "Medicaid Hospital Outpatient Supplemental Payment Act of 2013".

Editor's notes. — Applicability of D.C. Law 20-61: Section 11001 of D.C. Law 20-61 provided that, except as otherwise provided, the act shall apply as of October 1, 2013.

§ 44-658. Rules.

The Mayor, pursuant to subchapter I of Chapter 5 of Title 2 [§ 2-501 et seq.], may issue rules to implement the provisions of this chapter.

(Dec. 24, 2013, D.C. Law 20-61, § 5079, 60 DCR 12472.)

Emergency legislation. — For temporary (90 days) addition of this section, see § 5079 of the Fiscal Year 2014 Budget Support Emergency Act of 2013 (D.C. Act 20-130, July 30, 2013, 60 DCR 11384, 20 DCSTAT 1827).

For temporary (90 days) addition of this section, see § 5079 of the Fiscal Year 2014 Budget Support Congressional Review Emergency Act of 2013 (D.C. Act 20-204, October 17, 2013, 60 DCR 15341, 20 DCSTAT 2311).

Legislative history of Law 20-61. — See note to § 44-651.

Short title. — Section 5071 of D.C. Law 20-61 provided that Subtitle H of Title V of the act may be cited as the "Medicaid Hospital Outpatient Supplemental Payment Act of 2013".

Editor's notes. — Applicability of D.C. Law 20-61: Section 11001 of D.C. Law 20-61 provided that, except as otherwise provided, the act shall apply as of October 1, 2013.

§ 44-659. Applicability date; sunset.

(a) This chapter shall apply as of May 1, 2013.

(b) This chapter shall sunset as of September 30, 2014.

(Dec. 24, 2013, D.C. Law 20-61, § 5080, 60 DCR 12472.)

Emergency legislation. — For temporary (90 days) addition of this section, see § 5080 of the Fiscal Year 2014 Budget Support Emergency Act of 2013 (D.C. Act 20-130, July 30, 2013, 60 DCR 11384, 20 DCSTAT 1827).

Legislative history of Law 20-61. — See note to § 44-651.

Short title. — Section 5071 of D.C. Law 20-61 provided that Subtitle H of Title V of the act may be cited as the "Medicaid Hospital Outpatient Supplemental Payment Act of 2013".

Editor's notes. — Applicability of D.C. Law 20-61: Section 11001 of D.C. Law 20-61 provided that, except as otherwise provided, the act shall apply as of October 1, 2013.

CHAPTER 9A. NOT-FOR-PROFIT HOSPITAL CORPORATION.

§ 44-951.03. Not-for-Profit Hospital Corporation Fund.

(a)(1) There is established as a nonlapsing fund the Not-for-Profit Hospital Corporation Fund. The Fund shall be comprised of:

(A) Accounts receivable of the Corporation;

(B) Transferred funds of the United Medical Center; and

(C) Funds obtained through payments from third-party payers, and other sources.

(2) The Mayor may direct the Chief Financial Officer to deposit in the Fund any and all other funds received by or on behalf of the Corporation or the hospital for the purpose of operating the Corporation, the hospital, and any other operations conducted by or through the Corporation on the site.

(3) All funds deposited into the Fund, and any interest earned on those funds, shall not revert to the unrestricted fund balance of the General Fund of the District of Columbia at the end of a fiscal year, or at any other time, but shall be continually available for the uses and purposes set forth in subsection (b) of this section without regard to fiscal year limitation, subject to authorization by Congress.

(b) Disbursements from the Fund may be used for all purposes related to operating the Corporation, the hospital, and other operations on the site, and to purchase for the general public for educational or promotional events and programs sponsored or organized by the Corporation, including the Corporation's Marketing/Public Relations department:

(1) Food;

(2) Snacks;

(3) Nonalcoholic beverages; and

(4) Marketing and promotional items and gifts.

(Sept. 14, 2011, D.C. Law 19-21, § 5114, 58 DCR 6226; Sept. 20, 2012, D.C. Law 19-168, § 5032(a), 59 DCR 8025.)

Section references. — This section is referenced in § 44-951.01.

Effect of amendments. — The 2012 amendment by D.C. Law 19-168 added "and to purchase for the general public for educational or promotional events and programs sponsored or organized by the Corporation, including the Corporation's Marketing/Public Relations department" in the introductory language of (b); and added (b)(1) through (b)(4).

Legislative history of Law 19-168. — Law 19-168, the "Fiscal Year 2013 Budget Support Act of 2012," was introduced in Council and assigned Bill No. 19-743. The Bill was adopted on first and second readings on May 15, 2012, and June 5, 2012, respectively. Signed by the Mayor on June 22, 2012, it was assigned Act No. 19-385 and transmitted to Congress for its review. D.C. Law 19-168 became effective on September 20, 2012.

§ 44-951.06. Powers of the Corporation.

The Corporation shall have the power to:

(1) Sue and be sued in its corporate name;

(2) Adopt a corporate seal and alter the seal at its pleasure;

(3) Adopt, amend, and repeal bylaws governing the manner in which it may conduct business and how the powers vested in it may be exercised;

(4) Borrow money for any of its corporate purposes pursuant to § 44-951.05 and as may be permitted under Chapter 2 of Title 1, and other laws of the District; provided, that the Corporation's debts shall not be subject to and shall not be backed by the full faith and credit of the District of Columbia;

(5) Provide for the payment of obligations as may be permitted under Chapter 2 of Title 1 and other laws of the District;

(6) Establish polices for contracting and procurement that are consistent with the principles of competitive procurement and, subject to District law,

make and execute contracts, leases, and all other agreements or instruments necessary and appropriate for the exercise of its powers and the fulfillment of its corporate purposes;

(7) Subject to Council approval by resolution, acquire, construct, and dispose of real or personal property of every kind, including a health-care facility or an interest in a health-care facility for its corporate purposes;

(8) Operate, manage, superintend, maintain, repair, equip, and control a health-care facility under its jurisdiction, including seeking all necessary licenses, certifications, or other permits and establishing and collecting fees, rentals, or other charges, including reimbursement allowances for the sale, lease, or sublease of any health-care facility;

(9) Provide health and medical services to the public directly or by agreement with a person, firm, or private or public corporation or association;

(10) Establish policies governing admissions and health and medical services and fees and other charges, including reimbursement allowances for providing health and medical services;

(11) Provide and maintain resident physician and intern medical services, as appropriate, and sponsor and conduct research, development, planning, evaluation, educational, and training programs, as appropriate;

(12) Provide additional services and adopt a schedule of appropriate charges for additional services consistent with its corporate purposes;

(13) Employ officers, executives, and management personnel who may formulate or participate in the formulation of the plans, policies, and standards or who may administer, manage, or operate the Corporation, fix their qualifications, and prescribe their duties and other terms of employment, compensation, and benefits; except, that such personnel shall be excluded from collective bargaining representation and employ other personnel as may be necessary;

(14) Subject to the requirements of §§ 1-329.01, and 1-204.46b, apply for and receive donations, gifts, grants of money, real and personal property, services, or other aid;

(14A) Issue grants to promote healthcare programs, policies, and awareness;

(15) Maintain or purchase insurance, including errors and omissions insurance, for the Board and officers of the Corporation, or obtain indemnification against losses or liabilities of the Corporation;

(16) Enter into agreements with another organization, public or private, for goods and services as needed for its corporate purposes;

(17) Request and recommend that the Chief Financial Officer of the District of Columbia invest the Corporation's funds and make recommendations to the Chief Financial Officer of the District of Columbia how to administer funds;

(18) Retain or employ auditors, engineers, and private consultants by contract for rendering professional, management, or technical services and advice;

(19) Subject to District law, engage in a joint venture and participate in a network, alliance, consortium pool, or other cooperative arrangement with a public or private entity; and

(20) Do any and all things necessary and proper to carry out its corporate purposes.

(Sept. 14, 2011, D.C. Law 19-21, § 5117, 58 DCR 6226; Sept. 20, 2012, D.C. Law 19-168, § 5032(b), 59 DCR 8025.)

Effect of amendments. — The 2012 amendment by D.C. Law 19-168 added (14A).

Legislative history of Law 19-168. — See note to § 44-951.03.

§ 44-951.13. Reports to the Mayor and the Council.

Emergency legislation. — For temporary (90 day) addition of section, see § 5016 of Fiscal Year 2013 Budget Support Emergency Act of 2012 (D.C. Act 19-383, June 19, 2012, 59 DCR 7764).

For temporary (90 day) addition of section, see § 5016 of Fiscal Year 2013 Budget Support Congressional Review Emergency Act of 2012 (D.C. Act 19-413, July 25, 2012, 59 DCR 9290).

Editor's notes. — For Not-for-Profit Hospital Corporation reporting requirements to Council, see § 5016 of D.C. Law 19-168.

§ 44-951.18. Authority of the Chief Financial Officer.

The Chief Financial Officer of the District of Columbia shall exercise authority over the Corporation consistent with §§ 1-204.24a through 1-204.24f.

(Sept. 14, 2011, D.C. Law 19-21, § 5129, 58 DCR 6226; Sept. 26, 2012, D.C. Law 19-171, § 107, 59 DCR 6190.)

Effect of amendments. — The 2012 amendment by D.C. Law 19-171 substituted "§§ 1-204.24a through 1-204.24f" for "§§ 1-204.24a, 1-204.24b, and 1-204.24c."

Legislative history of Law 19-171. — Law 19-171, the "Technical Amendments Act of 2012," was introduced in Council and assigned Bill No. 19-397. The Bill was adopted on first and second readings on Mar. 20, 2012, and Apr. 17, 2012, respectively. Signed by the Mayor on May 23, 2012, it was assigned Act No. 19-376 and transmitted to Congress for its review. D.C. Law 19-171 became effective on September 26, 2012.

CHAPTER 12. SUBSTANCE ABUSE TREATMENT AND PREVENTION.

Sec.
44-1203.01. Privatization of residential substance abuse treatment.

§ 44-1203.01. Privatization of residential substance abuse treatment.

(a) Notwithstanding any provision of § 44-1203, the Mayor shall contract out the operation of the substance abuse Residential Short Stay and Detoxification Facilities programs that are currently operated by the Addiction, Prevention, and Recovery Administration ("APRA") and, when appropriate, priority shall be given to locating such facilities on the campus of the D.C. General Hospital. The affected employees of APRA shall be given the opportunity to compete in this privatization, which shall be carried out in accordance with § 2-352.05.

(b) Any amount of funding necessary for costs of severance pay related to the contracting out of the operation of the substance abuse Residential Short Stay and Detoxification Facilities program shall be paid from the administrative costs of the Addiction, Prevention, and Recovery Administration. No money for severance pay related to the contracting out shall be taken from any program funding allocated for substance abuse treatment services, including the $3 million increase allocated by the Council for community based substance abuse treatment services.

(Mar. 15, 1990, D.C. Law 8-80, § 4a, 36 DCR 8469, as added Oct. 20, 1999, D.C. Law 13-38, § 1702, 46 DCR 6373; Sept. 26, 2012, D.C. Law 19-171, § 218, 59 DCR 6190.)

Effect of amendments. — The 2012 amendment by D.C. Law 19-171 substituted "in accordance with § 2-352.05" for "in accordance with §§ 2-301.05b and 2-301.05c" in (a).

Legislative history of Law 19-171. — Law 19-171, the "Technical Amendments Act of 2012," was introduced in Council and assigned Bill No. 19-397. The Bill was adopted on first and second readings on Mar. 20, 2012, and Apr. 17, 2012, respectively. Signed by the Mayor on May 23, 2012, it was assigned Act No. 19-376 and transmitted to Congress for its review. D.C. Law 19-171 became effective on September 26, 2012.

SUBTITLE II. SPECIAL INSTITUTIONS.

CHAPTER 14. FOREST HAVEN.

§ 44-1401. Authority to acquire site and erect buildings; title to, and jurisdiction over, land.

The Mayor of the District of Columbia is authorized and directed to acquire a site for a home and school for persons with intellectual disabilities, said site to be located in the District of Columbia or in the State of Maryland or in the State of Virginia, and to erect thereon suitable buildings for a home and school persons with intellectual disabilities. The title to said land is to be taken directly to and in the name of the United States. But the land so acquired shall be under the jurisdiction of the Mayor of the District of Columbia as agent of the United States. The persons are to be admissible to said home and school and the proceedings with reference to securing such admission are to be in accordance with law.

(Feb. 28, 1923, 42 Stat. 1360, ch. 148, § 1; Sept. 26, 2012, D.C. Law 19-169, § 30, 59 DCR 5567.)

Section references. — This section is referenced in § 44-1402.

Effect of amendments. — The 2012 amendment by D.C. Law 19-169 substituted

"persons with intellectual disabilities" for "feebleminded persons" twice in the first sentence.

Legislative history of Law 19-169. — Law 19-169, the "People First Respectful Language Modernization Amendment Act of 2012," was introduced in Council and assigned Bill No. 19-189. The Bill was adopted on first and second readings on Mar. 6, 2012, and Apr. 17, 2012, respectively. Signed by the Mayor on May 15, 2012, it was assigned Act No. 19-361 and transmitted to Congress for its review. D.C. Law 19-169 became effective on Sept. 26, 2012.

Editor's notes. — Section 35 of D.C. Law 19-169 provided that no provision of the act shall impair any right or obligation existing under law.

§ 44-1402. Control and supervision; name.

The institution for the custody, care, education, training, and treatment of persons with intellectual disabilities, established by § 44-1401, shall be under the control and supervision of the Department of Human Services of the District, and shall be known as Forest Haven.

(Mar. 3, 1925, 43 Stat. 1135, ch. 460, § 1; Mar. 16, 1926, 44 Stat. 208, ch. 58, §§ 1, 2; Oct. 22, 1970, 84 Stat. 1087, Pub. L. 91-490, § 1(1); Sept. 26, 2012, D.C. Law 19-169, § 31, 59 DCR 5567.)

Effect of amendments. — The 2012 amendment by D.C. Law 19-169 substituted "persons with intellectual disabilities" for "substantially retarded persons."

Legislative history of Law 19-169. — Law 19-169, the "People First Respectful Language Modernization Amendment Act of 2012," was introduced in Council and assigned Bill No. 19-189. The Bill was adopted on first and second readings on Mar. 6, 2012, and Apr. 17, 2012, respectively. Signed by the Mayor on May 15, 2012, it was assigned Act No. 19-361 and transmitted to Congress for its review. D.C. Law 19-169 became effective on Sept. 26, 2012.

Editor's notes.

Section 35 of D.C. Law 19-169 provided that no provision of the act shall impair any right or obligation existing under law.

TITLE 45. COMPILATION AND CONSTRUCTION OF CODE.

Chapter 6. Rules of Construction.

§ 45-607. "Insane person" and "lunatic". [Repealed].

Repealed.

(Mar. 3, 1901, 31 Stat. 1189, ch. 854; Sept. 26, 2012, D.C. Law 19-169, § 23(a), 59 DCR 5567.)

Legislative history of Law 19-169. — Law 19-169, the "People First Respectful Language Modernization Amendment Act of 2012," was introduced in Council and assigned Bill No. 19-189. The Bill was adopted on first and second readings on Mar. 6, 2012, and Apr. 17, 2012, respectively. Signed by the Mayor on May 15, 2012, it was assigned Act No. 19-361 and transmitted to Congress for its review. D.C. Law 19-169 became effective on Sept. 26, 2012.

Editor's notes. — Section 35 of D.C. Law 19-169 provided that no provision of the act shall impair any right or obligation existing under law.

TITLE 46. DOMESTIC RELATIONS.

SUBTITLE I. GENERAL.

SUBTITLE I. GENERAL.

§ 46-101. Enumerated.

Section references. — This section is referenced in § 4-751.01 and § 38-201.

CASE NOTES

Applied in Wilson v. Hayes, 77 A.3d 392, 2013 D.C. App. LEXIS 654 (2013).

Chapter 2. Child Support and Medical Support Enforcement.

Subchapter I. Child Support Enforcement

Subchapter I. Child Support Enforcement.

§ 46-201. Definitions.

Section references. — This section is referenced in § 16-911, § 46-301.01, and § 47-1805.04.

LAW REVIEWS AND JOURNAL COMMENTARIES

The Intersection Between Welfare Reform and Child Support Enforcement: D.C.'s Weak Link, 52 Cath. U. L. Rev. 621 (2003).

§ 46-202.01. Collection and Disbursement Unit.

Section references. — This section is referenced in § 16-911 and § 46-205.

LAW REVIEWS AND JOURNAL COMMENTARIES

The Intersection Between Welfare Reform and Child Support Enforcement: D.C.'s Weak Link, 52 Cath. U. L. Rev. 621 (2003).

§ 46-225.02. Criminal contempt remedy for failure to pay child support.

Section references. — This section is referenced in § 16-916.01 and § 46-204.

LAW REVIEWS AND JOURNAL COMMENTARIES

The Intersection Between Welfare Reform and Child Support Enforcement: D.C.'s Weak Link, 52 Cath. U. L. Rev. 621 (2003).

§ 46-226.06. Directory of New Hires.

(a) The Mayor shall establish and maintain a District of Columbia Directory of New Hires, which shall contain information supplied in accordance with subsection (b) of this section.

(b) Except as specified in subsections (e), (f), and (g) of this section, within 20 days of the date an employee begins employment in the District of Columbia, or is rehired, the employer shall supply the following information to the District of Columbia Directory of New Hires:

(1) Name of the employee;

(2) Address of the employee;

(3) Social security number of the employee;

(4) Name of the employer;

(5) Address of the employer;

(6) Employer identification number issued to the employer under section 6109 of the Internal Revenue Code of 1986, approved October 22, 1986 (75 Stat. 828; 26 U.S.C. § 6109); and

(7) Date of hire of the employee, defined as the first day that the employee performed services for compensation.

(c) An employer may, at the employer's option, supply the following information to the District of Columbia Directory of New Hires:

(1) Name of an employer contact person;

(2) Telephone number of an employer contact person;

(3) Availability of medical insurance coverage for the employee and the date on which the employee became or will become eligible for the coverage, if appropriate;

(4) Date of birth of the employee; and

(5) Repealed;

(6) Employee's salary, wages, or other compensation.

(d) Each report required by subsection (b) of this section shall be:

(1) Made on an Internal Revenue Service W-4 form, or, at the option of the employer, an equivalent form;

(2) Transmitted by first-class mail, magnetically or electronically;

(3) Entered into the data base of the District of Columbia Directory of New Hires within 5 business days of receipt of the report from the employer; and

(4) Forwarded by the IV-D agency to the National Directory of New Hires within 3 business days of entry of the information under paragraph (3) of this subsection.

(e) An employer that transmits reports to the District of Columbia Directory of New Hires magnetically or electronically may transmit reports in up to 2 monthly transmissions, not less than 12 days nor more than 16 days apart.

(f) Within 2 business days after the date a report under subsection (b) of this section is entered into the District of Columbia Directory of New Hires, the IV-D agency shall transmit an order to withhold to the employer in accordance with this subchapter, unless the employee's income is not subject to withholding.

(g) An employer that has employees in the District and in at least one other state and transmits reports magnetically or electronically may comply with subsection (b) of this section by designating either the District or a state in which the employer has employees and transmitting reports on new hires only to the District or that state. Any employer transmitting reports pursuant to this subsection shall provide the United States Department of Health and Human Services with written notice of the jurisdiction the employer has designated.

(h) Any department, agency, or instrumentality of the United States shall comply with this section to the extent permitted by section 453A(b)(1)(C) of the Social Security Act, approved August 22, 1996 (110 Stat. 2216; 42 U.S.C. § 653(i)).

(i) An employer who fails to comply with this section shall be subject to a civil penalty of $25 for each employee with respect to whom the employer failed to comply or the employer shall be subject to a civil penalty of $500 for each employee with respect to whom the employer failed to comply if the noncompliance was the result of a conspiracy between the employer and the employee not to supply the required report or to supply a false or incomplete report. The employer shall be penalized each calendar month until the employer complies. Penalties pursuant to this subsection shall be enforced in the Court by the Attorney General for the District of Columbia.

(j) The Mayor may contract for services to carry out this section.

(k) The Mayor shall promulgate rules pursuant to subchapter I of Chapter 5 of Title 2, to implement the provisions of this section, including establishment of a procedure for an employer to challenge the imposition of a civil penalty pursuant to subsection (i) of this section, with a right to appeal the decision to the Court in accordance with the manner and standards for appeals as set forth in § 2-510.

(l) For purposes of this section, the term:

(1) "Employee" means a person who is an employee within the meaning of chapter 24 of the Internal Revenue Code of 1986, approved August 16, 1954 (68A Stat. 455; 26 U.S.C. § 3401 et seq.), but does not include an employee of

a federal or state agency performing intelligence or counterintelligence functions if the head of the agency has determined that reporting pursuant to this section could endanger the safety of the employee or compromise an ongoing investigation or intelligence mission.

(2) "Employer" has the meaning given to the term in section 3401(d) of the Internal Revenue Code of 1986, approved August 16, 1954 (68A Stat. 457; 26 U.S.C. § 3401(d)), and includes any governmental entity and any labor organization, as defined under section 2(5) of the National Labor Relations Act, approved July 5, 1935 (49 Stat. 450; 29 U.S.C. § 152(5)), including a hiring hall.

(3) "New hire" means an employee for whom an employer is required to complete a new Internal Revenue Service W-4 form.

(m) Information collected for the District of Columbia Directory of New Hires may be used by a federal agency, a state or District agency, or a private entity under contract with a government agency to:

(1) Establish paternity;

(2) Establish, modify, and enforce a support order;

(3) Administer worker's compensation and unemployment insurance programs; and

(4) Verify eligibility for public assistance programs.

(Feb. 24, 1987, D.C. Law 6-166, § 27f, as added Apr. 3, 2001, D.C. Law 13-269, § 108(z), 48 DCR 1270; Dec. 7, 2004, D.C. Law 15-205, § 3403(r), 51 DCR 8441; Apr. 13, 2005, D.C. Law 15-354, § 71, 52 DCR 2638; May 12, 2006, D.C. Law 16-100, § 3(cc), 53 DCR 1886; Mar. 3, 2007, D.C. Law 16-191,§ 48(g), 54 DCR 6794; Mar. 19, 2013, D.C. Law 19-225, § 2, 59 DCR 13551.)

Section references. — This section is referenced in § 46-207.01, § 46-216, and § 46-251.02.

Effect of amendments.

The 2013 amendment by D.C. Law 19-225 added (b)(7); repealed (c)(5), which read: "Date of hire of the employee, defined as the first day that the employee performed services for compensation; and"; and made related changes.

Legislative history of Law 19-225. — Law 19-225, the "Hire Date Reporting Amendment Act of 2012," was introduced in Council and assigned Bill No. 19-739. The Bill was adopted on first and second readings on Oct. 16, 2012, and Nov. 1, 2012, respectively. Signed by the Mayor on Nov. 15, 2012, it was assigned Act No. 19-536 and transmitted to Congress for its review. D.C. Law 19-225 became effective on Mar. 19, 2013.

CHAPTER 4. MARRIAGE.

§ 46-401. Equal access to marriage.

(a) Marriage is the legally recognized union of 2 persons. Any person may enter into a marriage in the District of Columbia with another person,

regardless of gender, unless the marriage is expressly prohibited by § 46-401.01 or § 46-403.

(b) Where necessary to implement the rights and responsibilities relating to the marital relationship or familial relationships, gender-specific terms shall be construed to be gender neutral for all purposes throughout the law, whether in the context of statute, administrative or court rule, policy, common law, or any other source of civil law.

(Mar. 3, 1901, 31 Stat. 1391, ch. 854, § 1283, as added Mar. 3, 2010, D.C. Law 18-110, § 2(b), 57 DCR 27.)

Section references. — This section is referenced in § 32-702.

§ 46-404. Persons allowed to institute annulment proceedings.

A proceeding to declare the nullity of a marriage may be instituted in the case of an infant under the age of consent by such infant, through a next friend, or by the parent or guardian of such infant; and in the case of a person with mental illness, by next friend. But no such proceedings shall be allowed to be instituted by any person who, being fully capable of contracting a marriage, has knowingly and wilfully contracted any marriage declared illegal by the foregoing sections.

(Mar. 3, 1901, 31 Stat. 1392, ch. 854, § 1286; June 30, 1902, 32 Stat. 543, ch. 1329; Sept. 26, 2012, D.C. Law 19-169, § 23(e), 59 DCR 5567.)

Effect of amendments. — The 2012 amendment by D.C. Law 19-169 substituted "a person with mental illness" for "an idiot or lunatic" in the first sentence.

Legislative history of Law 19-169. — Law 19-169, the "People First Respectful Language Modernization Amendment Act of 2012," was introduced in Council and assigned Bill No. 19-189. The Bill was adopted on first and second readings on Mar. 6, 2012, and Apr. 17, 2012, respectively. Signed by the Mayor on May 15, 2012, it was assigned Act No. 19-361 and transmitted to Congress for its review. D.C. Law 19-169 became effective on Sept. 26, 2012.

Editor's notes. — Section 35 of D.C. Law 19-169 provided that no provision of the act shall impair any right or obligation existing under law.

§ 46-406. Persons authorized to celebrate marriages.

(a) For the purposes of this section, the term:

(1) "Civil celebrant" means a person of a secular or non-religious organization who performs marriage ceremonies.

(2) "Religious" includes or pertains to a belief in a theological doctrine, a belief in and worship of a divine ruling power, a recognition of a supernatural power controlling man's destiny, or a devotion to some principle, strict fidelity or faithfulness, conscientiousness, pious affection, or attachment.

(3) "Society" means a voluntary association of individuals for religious purposes.

(4) "Temporary officiant" means a person authorized by the Clerk of the Superior Court of the District of Columbia ("Court") to solemnize a specific

marriage. The person's authority to solemnize that marriage shall expire upon the filing of the marriage license, pursuant to § 46-412.

(b) For the purpose of preserving the evidence of marriages in the District of Columbia, a marriage authorized under this chapter may be solemnized by the following persons at least 18 years of age at the time of the marriage:

(1) A judge or retired judge of any court of record;

(2) The Clerk of the Court or such deputy clerks of the Court as may, in writing, be designated by the Clerk and approved by the Chief Judge of the Court;

(3) A minister, priest, rabbi, or authorized person of any religious denomination or society;

(4) For any religious society which does not by its own custom require the intervention of a minister for the celebration of marriages, a marriage may be solemnized in the manner prescribed and practiced in that religious society, with the license issued to, and returns to be made by, a person appointed by the religious society for that purpose;

(5) A civil celebrant;

(6) A temporary officiant;

(7) Members of the Council;

(8) The Mayor of the District of Columbia; or

(9) The parties to the marriage.

(b-1) All persons authorized by subsection (b) of this section to solemnize marriages shall comply with the requirements of § 46-412.

(b-2) The Court shall charge a reasonable registration fee for authorization to solemnize marriages; provided, that the registration fee for a temporary officiant shall not exceed $25.

(c) No priest, imam, rabbi, minister, or other official of any religious society who is authorized to solemnize or celebrate marriages shall be required to solemnize or celebrate any marriage.

(d) Each religious society has exclusive control over its own theological doctrine, teachings, and beliefs regarding who may marry within that particular religious society's faith.

(e)(1) Notwithstanding any other provision of law, a religious society, or a nonprofit organization that is operated, supervised, or controlled by or in conjunction with a religious society, shall not be required to provide services, accommodations, facilities, or goods for a purpose related to the solemnization or celebration of a marriage, or the promotion of marriage through religious programs, counseling, courses, or retreats, that is in violation of the religious society's beliefs.

(2) A refusal to provide services, accommodations, facilities, or goods in accordance with this subsection shall not create any civil claim or cause of action, or result in a District action to penalize or withhold benefits from the religious society or nonprofit organization that is operated, supervised, or controlled by or in conjunction with a religious society.

(Mar. 3, 1901, 31 Stat. 1392, ch. 854, § 1288; Apr. 23, 1904, 33 Stat. 297, ch. 1490, § 1; June 25, 1948, 62 Stat. 991, ch. 646, § 32(a), (b); May 24, 1949, 63

Stat. 107, ch. 139, § 127; July 5, 1966, 80 Stat. 264, Pub. L. 89-493, § 13(a), (b); July 29, 1970, 84 Stat. 570, Pub. L. 91-358, title I, § 155(a); Jan. 26, 1982, D.C. Law 4-60, § 2, 28 DCR 4768; Mar. 3, 2010, D.C. Law 18-110, § 2(d), 57 DCR 27; Nov. 5, 2013, D.C. Law 20-36, § 2, 60 DCR 12143.)

Section references. — This section is referenced in § 46-412.

Effect of amendments.

The 2013 amendment by D.C. Law 20-36 rewrote (a) and (b); and added (b-1) and (b-2).

Legislative history of Law 20-36. — Law 20-36, the "Marriage Officiant Amendment Act of 2013," was introduced in Council and assigned Bill No. 20-118. The Bill was adopted on first and second readings on June 26, 2013, and July 10, 2013, respectively. Signed by the Mayor on August 6, 2013, it was assigned Act No. 20-152 and transmitted to Congress for its review. D.C. Law 20-36 became effective on November 5, 2013.

§ 46-421. Violations; prosecutions.

Whoever: (1) knowingly divulges, other than in accordance with the provisions of §§ 46-416 to 46-421, any information, derived from the laboratory blood test required by § 46-417 [repealed], relating to any person who has, or [is] suspected to have, syphilis; (2) knowingly misrepresents any fact called for by the statement required by such section, or knowingly falsifies any material fact in connection with the laboratory blood test required by such section; (3) knowingly issues a marriage license without having received the statement required under such section or an order of the Superior Court of the District of Columbia issued under § 46-418; or (4) otherwise fails to comply with any other provision of §§ 46-416 to 46-421; shall be imprisoned for not more than 6 months, or fined not more than $250, or both. Prosecutions for violations of this section shall be conducted by the Attorney General for the District of Columbia.

(Oct. 15, 1966, 80 Stat. 960, Pub. L. 89-682, § 6; July 7, 1967, 81 Stat. 122, Pub. L. 90-53, § 1; July 29, 1970, 84 Stat. 570, Pub. L. 91-358, § 155(a); Apr. 13, 2005, D.C. Law 15-354, § 72, 52 DCR 2638; Sept. 26, 2012, D.C. Law 19-169, § 32, 59 DCR 5567.)

Effect of amendments.

The 2012 amendment by D.C. Law 19-169 substituted "relating to any person who has, or suspected to have, syphilis" for "relating to any person suffering, or suspected to be suffering from, syphilis."

Legislative history of Law 19-169. — Law 19-169, the "People First Respectful Language Modernization Amendment Act of 2012," was introduced in Council and assigned Bill No. 19-189. The Bill was adopted on first and second readings on Mar. 6, 2012, and Apr. 17, 2012, respectively. Signed by the Mayor on May 15, 2012, it was assigned Act No. 19-361 and transmitted to Congress for its review. D.C. Law 19-169 became effective on Sept. 26, 2012.

Editor's notes. — Section 35 of D.C. Law 19-169 provided that no provision of the act shall impair any right or obligation existing under law.